



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 8, 2024

Licensee
Metro Assisted Living
7663 Jackson Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL35903015

Dear Licensee:

On November 5, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 20, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 10, 2024

Licensee
Metro Assisted Living
7663 Jackson Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL35903015

Dear Licensee:

On September 4, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 2, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 20, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 20, 2024, found not corrected at the time of the September 4, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0495-Minimum Requirements-144g.41 Subd. 1 (14) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on September 4, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request

for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

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. to submit a hearing request, please visit:

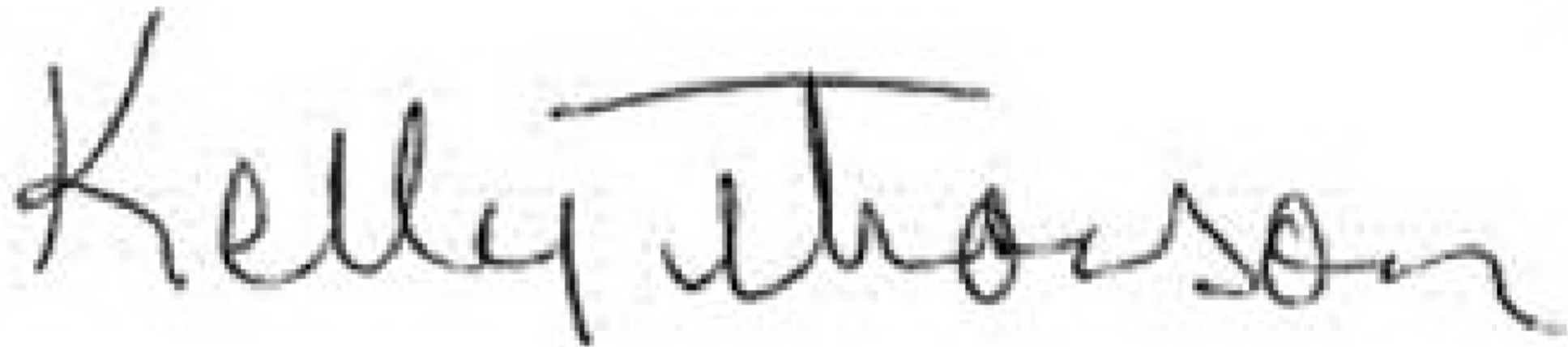
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Kelly Thorson at 320-223-7336.

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

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/04/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7663 JACKSON STREET NE FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35903015-1 On September 3, 2024 through September 4, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 20, 2024. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480			

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0 480	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	0 480			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required.	0 490			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week	{0 495}			

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{0 495}	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff and residents had access to a registered nurse ((clinical nurse supervisor) (CNS)-B) on-call for current and foreseeable needs 24 hours a day, seven days per week due to CNS-B holding other employment at another health care provider. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 3, 2024, at 8:58 a.m., the surveyor initiated a follow-up survey with provider via email that requested current rosters and plan of correction for orders that were issued at the previous survey that had been completed on June 20, 2024. At 9:15 a.m., the surveyor spoke with licensed assisted living director (LALD)-A who confirmed the email was received and will send the requested information via email shortly. On September 3, 2024, at 10:42 a.m., the surveyor received via email a plan of correction to ensure licensee has an on-call nurse available 24/7 that indicated the following correction steps: - 7/1/2024 - director met with current RN to evaluate the current RN's availability and	{0 495}			

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{0 495}	Continued From page 4 willingness to increase on-call hours. During the meeting, RN stated her willingness to take a leave from the overnight position and work with our facility full-time effective July 15th 2024. During the meeting, we addressed areas of noncompliance as follows: -We identified areas of non-compliance and corrected it by having a RN available on-call at all times. By converting current PT RN to FT RN and having her agree to be available at all times, we have corrected the non-compliance related to residents and employees. - 7/14/2023 - director met with all staff to inform them on scheduling changes for CNS-B. All active staff were part of the meeting. - 7/15/2024 - effective immediately, current PT RN will be converting full time at least the next three months. During this period, RN Understands that they need to be available to work in-person, virtually, and on-call 24/7. - 8/12/24 - scheduled a meeting with nursing agency to cover on call nursing duties starting in October 2024. - 8/20/2024 - meeting was cancelled due to scheduling conflict. Will look to reschedule after Labor Day weekend. On September 3, 2024, at 12:19 p.m., the surveyor called and spoke via telephone with CNS-B who stated she is working full-time for the licensee and taking all the on-call schedule until the end of this month and the plan is to hire another RN to split the on-call schedule with, but no one has been hired yet. CNS-B stated she is still working at a hospital but is now only working one weekend a month and is not picking up additional shifts until another RN can be hired. On September 4, 2024, at 9:33 a.m., the surveyor called and spoke via telephone with LALD-A who	{0 495}			

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{0 495}	Continued From page 5 stated they had a meeting scheduled with the nursing agency owner (NAO)-C to finalize a contract in August for a backup on-call RN, but due to scheduling conflicts they rescheduled to meet sometime after Labor Day weekend and he just happened to receive an email from NAO-C yesterday, but did not contact her after the initiation of survey. LALD-A stated CNS-B was working for the licensee full-time and taking all of the on-call schedule. LALD-A stated CNS-B was originally going to take a leave of absence from her hospital job, but then changed her mind and is now only working one weekend a month at the hospital completing clerical work at a desk and can answer her phone if needed. LALD-A stated the contract with the nursing agency was not completed prior to the start of this follow-up survey and does not start until October 2024, but he could have the date of the contract changed to start today. On September 4, 2024, at 9:54 a.m., the surveyor called and left a message for CNS-B to call the surveyor back as soon as able. On September 4, 2024, at 9:57 a.m., the surveyor called and spoke via telephone with NAO-C who stated LALD-A called them yesterday to complete the contract for on-call nursing services. NAO-C stated herself and LALD-A had a conversation about a month ago to discuss what nursing services the agency could provide for a on-call back up nurse, however, there was no meeting scheduled to put a contract into place until yesterday when LALD-A contacted them requesting a contract. On September 4, 2024, at 10:43 a.m., the surveyor called CNS-B again and was able to speak with her via telephone. CNS-B stated, "I	{0 495}			

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{0 495}	Continued From page 6 am not the charge nurse as often unless one is needed, now I am just a floor nurse on the medical/surgical unit at the hospital". The licensee's Availability of an RN for Staff policy dated August 1, 2021, indicated the licensee will have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. No further information was provided.	{0 495}			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550			

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0 550	Continued From page 7 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	0 550			
{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	{0 650}			

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{0 650}	Continued From page 8 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}			

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{0 680}	Continued From page 9	{0 680}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	{0 800}			

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{0 800}	Continued From page 10 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	{0 810}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 810}	Continued From page 11 (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: No further action required.	{0 810}			
{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}			

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{01470}	Continued From page 12 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: No further action required.	{01470}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	{01500}			

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{01500}	Continued From page 13 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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:	{01500}			

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{01500}	Continued From page 14 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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: No further action required.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	{01530}			

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{01530}	Continued From page 15 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: No further action required.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living 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	{01620}			

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{01620}	Continued From page 16 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{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: No further action required.	{01770}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: No further action required.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 10, 2024

Licensee
Metro Assisted Living
7663 Jackson Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL35903015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 20, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

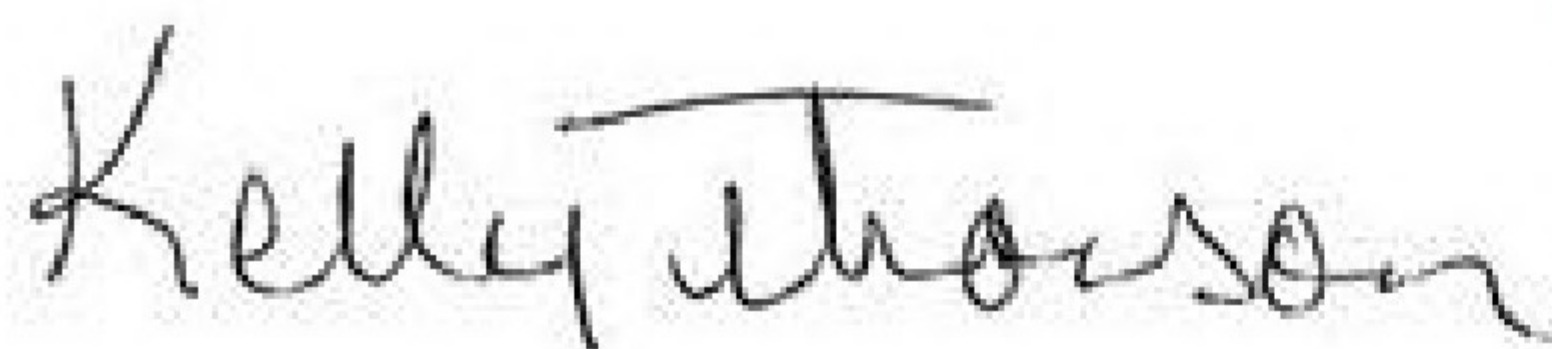
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2024
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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: SL35903015-0 On June 17, 2024, through June 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 resident(s); 4 receiving services under the provider's Assisted Living license. An immediate correction order was identified on June 18, 2024, issued for SL35903015-0 tag identification 0495. On June 19, 2024, at 8:00 a.m., the immediacy of correction order 0495 was removed, however, non-compliance remained at a scope and level of F.	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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a 24-hour staffing schedule in a central location. 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	0 470			

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a bed capacity of five residents and had four residents receiving services. On June 17, 2024, at 10:30 p.m., during the entrance conference the surveyor observed a scheduled posted on the bulletin board in the dining room. On June 17, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated the schedule posted is an old schedule that includes an employee that no longer works for the licensee and would need to be updated with a current one. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	0 480			

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0 480	Continued From page 3 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 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 17, 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			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;	0 490			

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0 490	Continued From page 4 (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. 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) 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 June 17, 2024, and June 18, 2024, the surveyor did not observe any activities planned or offered to the residents. On June 17, 2024, at 11:15 a.m., during a tour of the facility, the surveyor observed there was not an activity calendar posted in any part of the facility. On June 17, 2024, at 12:58 p.m., licensed assisted living director (LALD)-A stated there is usually an activities schedule posted but they were unable to locate it today. LALD-A stated staff might have taken it down to make modifications and LALD-A would talk to staff to	0 490			

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0 490	Continued From page 5 find out what happened to it. On June 18, 2024, at 3:15 p.m., LALD-A confirmed they had not been able to locate the June activity schedule. LALD-A stated the staff developed the activity schedule by talking with R4 because R4 drives and takes the some of the other residents out in the community. The activity schedule for all residents was developed around those activities. On June 18, 2024, at 5:15 p.m., the surveyor observed no activities calendar posted where LALD-A stated it should be. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 490			
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff and residents had access to a registered nurse ((clinical nurse supervisor) (CNS)-B) on-call for current and foreseeable needs 24 hours a day, seven days per week due to CNS-B holding other employment at another health care provider. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 495			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7663 JACKSON STREET NE FRIDLEY, MN 55432		
(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
0 495	Continued From page 6 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 17, 2024, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated they currently employee one nurse, CNS-B. LALD-A stated CNS-B was at home and was currently trying to find a babysitter so that she could come into the facility to participate in the survey but was available by phone. LALD-A also stated that CNS-B has another job at the hospital in addition to being the clinical nurse supervisor at this facility. On June 17, 2024, the facility had a census of four residents. Their diagnoses included anxiety, attention deficit hyperactivity disorder, depression, obesity, hypothyroidism, autism, borderline intellectual functioning, and history of stroke. The cares provided included assistance with medication administration, dressing and grooming, bathing assistance, behavior modification, housekeeping, laundry, and meal preparation. On June 18, 2024, at 9:30 a.m., CNS-B stated that she works at the hospital on the night shift on the medical/surgical unit but is always available by phone call or text for the staff at the facility. On June 18, 2024, at 2:40 p.m., via telephone interview with the surveyor, unlicensed personnel (ULP)-D stated they contact CNS-B by text message when needed for resident needs or emergencies. When asked what they would do if unable to reach CNS-B, ULP-D stated they would	0 495			

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0 495	Continued From page 7 call 911. ULP-D stated they did not recall any occurrences when CNS-B did not respond to their text message immediately. ULP-D stated they were trained upon hire by CNS-B to contact CNS-B by call or text but instructed to call 911 if unable to reach CNS-B. On June 18, 2024, at 2:50 p.m., ULP-C stated they were trained to call or text CNS-B for any medical questions, vital signs out of normal range, medical crisis, and questions about resident care. When asked what they would do if unable to reach CNS-B, ULP-C stated they would contact LALD-A, and if unable to reach LALD-A they would call 911. ULP-C stated they did not recall any specific times they called LALD-A instead of CNS-B. ULP-C stated they had not called 911 for anything for over one year. On June 18, 2024, at 3:51 p.m., CNS-B stated that she works part time at a hospital and the shifts were 7:00 p.m. to 7:00 a.m., or 11:00 p.m. to 7:00 a.m. CNS-B stated she is scheduled at the hospital for one weekend a month and then various days during the week to make up a 0.60 schedule. CNS-B stated that she works as both a floor nurse and a charge nurse for the hospital. CNS-B stated the job duties for a floor nurse include medication administration, treatments, personal cares, assessments, communication with intradisciplinary team, and new admissions to the unit. CNS-B stated the job duties of the charge nurse include receiving new admissions on the unit, communication with intradisciplinary team, assignments for the nurses on the floor, cosign for medications, two-person skin assessments, overseeing the nurses on the floor, and creating assignments for the oncoming shift. CNS-B stated if a patient had a cardiac arrest, she would be responsible for starting	0 495			

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0 495	Continued From page 8 cardiopulmonary resuscitation (CPR) and then calling the code team which would take over the code upon arrival. CNS-B stated there has not been a time where she has been unable to return a call or text from the staff at the assisted living facility and there has not been a time where she has needed to leave the job at the hospital to come into the facility. The licensee's Availability of an RN for Staff policy dated August 1, 2021, indicated the licensee will have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 19, 2024, the licensee submitted a plan of correction for tag 0495.	0 495			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510			

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0 510	Continued From page 9 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 that complies with accepted health care, medical and nursing standards for infection control related to handwashing by one of one unlicensed personnel (ULP-C) during medication administration. 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 June 18, 2024, at 8:00 a.m., ULP-C failed to perform hand hygiene prior to R3's medication administration. On June 18, 2024, at 8:15 a.m., ULP-C stated she was trained by the registered nurse (RN) and was trained to wash her hands before administering medications but had forgotten to wash them before giving R3 their medications. On June 18, 2024, at 9:05 a.m., clinical nursing supervisor (CNS)-B stated they would expect staff to wash their hands prior to medication	0 510			

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0 510	Continued From page 10 administration. The licensee's Infection Control Hand Washing policy dated August 1, 2021, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required	0 550			

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0 550	Continued From page 11 information related to the grievance procedure. This had the potential to affect all the licensee's current 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 June 17, 2024, at 10:30 a.m., during the entrance conference, the surveyor did not observe information about the licensee's complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. On June 17, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated the resident's are given a grievance form upon admission but the form and contact information on who they should contact for a grievance is not posted. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated a facility complaint form should be filled out by the resident, resident representative, or employee and given the supervisor of the department or to the Assisted Living Director. No further information was provided. TIME PERIOD FOR CORRECTION:	0 550			

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0 550	Continued From page 12 Twenty-One (21) days	0 550			
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

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0 650	Continued From page 13 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: CNS-B CNS-B had a hire date of October 6, 2021. CNS-B's employee record did not contain any performance evaluations. ULP-C ULP-C had a hire date of June 26, 2021. ULP-C's employee record did not contain any performance evaluations. On June 18, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A stated they had been unable to locate the requested performance reviews. LALD-A stated there was a form for performance reviews but was unable to produce the blank form. LALD-A stated they had not completed formal performance reviews with any employees but did discuss performance with individuals as needs arose. LALD-A stated they would make performance reviews for all employees' part of annual training. The licensee's Employee Records policy dated August 1, 2021, indicated employee records for each person would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660			

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0 660	Continued From page 14 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of four employees (clinical nurse supervisor (CNS)-B). 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: The licensee's TB Risk Assessment last	0 660			

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0 660	Continued From page 15 completed on August 1, 2023, indicated the facility's risk level to be low. CNS-B had a hire date of October 6, 2021. CNS-B's employee record included a Baseline TB Screening Tool for Healthcare Workers (HCW) form dated October 6, 2021which indicated CNS-B had never had a positive reaction to a TB skin test or TB blood test and had not had a TB skin test within the past twelve months. The form lacked information on current plan or results for TB blood testing or TB skin testing. CNS-B's employee record included a chest x-ray study result printed from Epic Systems Corporation MyChart on December 29, 2021. The study results lacked date the chest x-ray was performed, lacked information of indication for TB screening, and lacked rule out or findings related to TB. On June 18, 2024, at 10:00 a.m., licensed assisted living director (LALD)-A, stated they did not realize CNS-B's chest x-ray report on file lacked information required to rule out TB. LALD-A was not aware of a history of positive TB testing needed to be included in employee record for a chest x-ray to be used for TB screening. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated: "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.	0 660			

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0 660	Continued From page 16 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 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			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680			

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0 680	Continued From page 17 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 17, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A provided the evaluator with a binder that contained the emergency preparedness manual and indicated the contents were the licensee's EP plan. The licensee's emergency preparedness plan (EPP), dated August 1, 2021, lacked the required content: - annual review; - missing resident quarterly review; - description of the population served by licensee; - a process for EP collaboration with state and local EP officials/organizations; - the development of policies/procedures to	0 680			

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0 680	Continued From page 18 address: - subsistence needs for staff and patients; - procedures for tracking staff and residents; - procedures for medical documents; - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by Secretary. - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; and - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care. On June 17, 2024, at 3:45 p.m., LALD-A agreed their emergency preparedness plan was missing some of the required content, did not have signatures indicating an annual review, or have the missing person policy reviewed quarterly. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and	0 680			

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0 680	Continued From page 19 document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation 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, 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).	0 800			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 20 The findings include: On June 17, 2024, at 9:45 a.m. survey staff toured the facility with licensed assisted living director (LALD)-A. The following was observed: It was observed that the sliding closet door in bedroom #3 was pulled off its track and resting against the closet shelf. LALD-A stated that the resident had just knocked it off the track the day before. It was observed that a black metal chair in the dining area had a seat cushion that was not secured to the metal frame. The seat came off the frame completely. It was observed that the paint on the ceiling and ductwork adjacent to the downstairs bathroom was peeling and falling from the ceiling. It was observed that the outdoor furniture provided for resident use in the activities area was not maintained. The paint was peeling off all the surfaces and the benches and tabletop were rough and splintered from heavy weathering. It was observed that the deck was not maintained. The paint was peeling off the deck boards and guardrails. The wood was splintered from heavy weathering. It was observed that the yard had miscellaneous construction materials such as shingles and concrete blocks stored alongside the house. During interview, on June 20, 2024, at 1:00 p.m., LALD-A stated they understood the above-listed deficiencies.	0 800			

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0 800	Continued From page 21	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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 17, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated 8/01/2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

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0 810	Continued From page 23 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on June 20, 2024, at 1:00 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for staff on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 24 During an interview on June 20, 2024, at 1:00 p.m., LALD-A stated they understood the requirements and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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 Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470			

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01470	Continued From page 25 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 employees completed required orientation before providing services for four of five direct care employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, ULP-E, and ULP-F). 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	01470			

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01470	Continued From page 26 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: CNS-B CNS-B was hired on October 6, 2021, to provide direct care services to residents. CNS-B's employee record included an Educare (online training platform) transcript which lacked training for the following required orientation topics: - an overview of assisted living statutes; - review of provider policies and procedures; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - principles of person-centered planning and service delivery; - handling of residents' complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-D ULP-D was hired on November 7, 2023, to provide direct care services to residents. ULP-D's employee record included an Educare (online training platform) transcript which lacked training for the following required orientation topics:	01470			

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01470	Continued From page 27 - an overview of assisted living statutes; - review of provider policies and procedures; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - handling of residents' complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-E ULP-E was hired on June 1, 2020, to provide direct care services to residents. ULP-E's employee record included an Educare (online training platform) transcript which lacked training for the following required orientation topic: - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; ULP-F ULP-F was hired on December 19, 2022, to provide direct care services to residents. ULP-F's employee record included an Educare (online training platform) transcript which lacked training for the following required orientation topics: - an overview of assisted living statutes; - review of provider policies and procedures; - handling of emergencies and use of emergency services; - compliance with and reporting of the	01470			

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01470	Continued From page 28 maltreatment of vulnerable adults; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - handling of residents' complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On June 18, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A stated they were the individual responsible for assigning online education and ensuring the online education was completed. LALD-A stated they must have missed checking some of the new hire education records but understood the education needed to be completed prior to new hires providing resident care. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated all new employees must complete the orientation on all required topics before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500			

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01500	Continued From page 29 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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	01500			

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01500	Continued From page 30 challenges it poses to communication; (2) the 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 employees received at least eight hours of annual training for each twelve months of employment for four of four employees (clinical nurse supervisor (CNS)-B, unlicensed personnel ULP-C, ULP-E, and ULP-F). 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: CNS-B CNS-B was hired on October 6, 2021, to provide direct care services to residents. CNS-B's employee record lacked required annual review of provider policies and procedures for	01500			

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01500	Continued From page 31 2022, 2023, and 2024. ULP-C ULP-C was hired on June 26, 2021, to provide direct care services to residents. ULP-C's employee record lacked required annual review of provider policies and procedures for 2023 and 2024. ULP-E ULP-E was hired on June 1, 2020, to provide direct care services to residents. ULP-E's employee record lacked required annual review of provider policies and procedures for 2022, 2023, and 2024. ULP-F ULP-F was hired on December 19, 2022, to provide direct care services to residents. ULP-F's employee record lacked required annual review of infection control techniques for 2023 and review of provider policies and procedures for 2023 and 2024. On June 18, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A stated they were the individual responsible for assigning online education and ensuring the online education was completed. LALD-A stated they implemented assigning annual training in January for all employees in 2023. LALD-A stated provider policies and procedures were moved from paper to the provider's electronic medical record system (R Tasks) in 2022. LALD-A stated records of training prior to that were not retained. Employees were now required to review policies and procedures in R Tasks with all other annual	01500			

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01500	Continued From page 32 training every January. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services would complete at least eight hours of annual training for each twelve months of employment. This training would include review of the facility's policies and procedures and principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	01530			

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01530	Continued From page 33 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training for two of five direct care employees (clinical nurse supervisor (CNS)-B and and unlicensed personnel (ULP)-F). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for three of four direct care employees (CNS-B, ULP-C, and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B CNS-B was hired on October 6, 2021, to provide direct care services to residents. CNS-B's employee record included 6.75 hours of dementia training in November and December of 2021, however lacked the required full eight hours of initial training within 120 hours of the start date for providing direct care to assisted	01530			

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01530	Continued From page 34 living residents. CNS-B's employee record lacked the required two hours of annual dementia training for 2022 and 2024. ULP-C ULP-C was hired on June 26, 2021, to provide direct care services to residents. ULP-C's employee record lacked the required two hours of annual dementia training for 2022. ULP-E ULP-E was hired on June 1, 2020, to provide direct care services to residents. ULP-E's employee record lacked the required two hours of annual dementia training for 2022, 2023, and 2024. ULP-F ULP-F was hired on December 19, 2022, to provide direct care services to residents. ULP-F's employee record included 5 hours of dementia training in December of 2022, however lacked the required full eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents. On June 18, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A stated they were the individual responsible for assigning online education and ensuring the online education was completed. LALD-A stated they implemented assigning annual training in January for all employees in 2023 and was unsure why this training was missed.	01530			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7663 JACKSON STREET NE FRIDLEY, MN 55432			
(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
01530	Continued From page 35 LALD-A acknowledged CNS-B had worked at least one-hundred twenty hours and ULP-F had worked more than 160 hours for the licensee. The licensee's Dementia Training policy dated August 1, 2021, indicated all employees were required to complete dementia training at the time of hire and annually thereafter. In addition, all direct care employees would have completed at least eight hours of initial dementia training within one-hundred sixty working hours of their employment start date, supervisors of direct care employees would have completed eight hours of initial dementia training within one-hundred twenty hours of their employment start date, and all employees would have completed two hours of additional training for each twelve months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living 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	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2024
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01620	Continued From page 36 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for four of four residents (R2, R3, R4, and R5). 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: R2 R2 admitted to the licensee on September 15, 2021, with diagnoses that included attention deficit hyperactivity disorder and adjustment disorder. R2's Service Plan dated September 14, 2022,	01620			

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01620	Continued From page 37 indicated R2 received services for behavior management, dressing, housekeeping, laundry, and meal reminders. R2's record included 90-day assessments dated September 19, 2023, December 27, 2023, and April 6, 2024. The following R2 90-day assessments were completed late: - December 27, 2023, by 9 days; - April 6, 2024, by 11 days. R3 R3 admitted to the licensee on December 15, 2020, under the liensee's former comprehensive license and began receiving assisted living services August 1, 2021, with diagnoses that included attention deficit hyperactivity disorder, anxiety, autism, developmental disorder, and adjustment disorder. R3's Service Plan dated September 14, 2022, indicated R3 received services for medication administration, behavior management, dressing, housekeeping, laundry, and meal reminders. R3's record included 90-day assessments dated May 3, 2023, September 19, 2023, December 27, 2023, and April 6, 2024. The following R3 90-day assessments were completed late: - September 19, 2023, by 49 days; - December 27, 2023, by 9 days; and - April 6, 2024, by 11 days. R4 R4 admitted to the licensee on March 22, 2023, with diagnoses that included anxiety, depression,	01620			

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01620	Continued From page 38 obesity, and borderline intellectual functioning. R4's Service Plan dated March 22, 2023, indicated R4 received services for medication administration, behavior management, dressing, housekeeping, laundry, and meal reminders. R4's record included 90-day assessments dated October 4, 2023, January 3, 2024, and April 6, 2024. The following R4 90-day assessments were completed late: - January 3, 2024, by 1 days; and - April 6, 2024, by 4 days. R5 R5 admitted to the licensee on January 18, 2024, with diagnoses that included history of stroke, depression, anxiety, hypertension, and diabetes mellitus type 2. R5's signed service plan, dated January 18, 2024, indicated R5 received assistance with medication administration, med set up, behavior management, housekeeping, laundry, and meal reminders. R5's record included an admission assessment dated January 19, 2024, 14 day assessment dated February 2, 2024, and a 90 day assessment dated March 1, 2024. The following R5 90-day assessment was missing and late: -May 30, 2024, by 19 days. On June 18, 2024, at 8:53 a.m., clinical nurse supervisor (CNS-B), stated due to scheduling conflicts the assessments of all the residents	01620			

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01620	Continued From page 39 were late. The licensee's Assessments, Reviews and Monitoring policy dted July 25, 2022, indicated 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 additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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 a medication setup was accurate for one of four residents (R5). 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	01770			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2024
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01770	Continued From page 40 situation has occurred only occasionally). The findings include: R5's diagnosis included history of stroke, depression, anxiety, hypertension, and diabetes mellitus type 2. R5's signed service plan, dated January 18, 2024, indicated R5 received assistance with medication administration, med set up, behavior management, housekeeping, laundry, and meal reminders. R5's med set up review summary dated June 1, 2024, to June 30, 2024, indicated clinical nurse supervisor (CNS)-B set up all medications for R5 on June 3, 2024, June 10, 2024, and June 17, 2024. On June 18, 2024, at 3:45p.m., the surveyor observed all the medications for R5. These included a medication bar and two punch packs from the pharmacy. In the medication bar for R5 there were two white tablets in the Friday 2pm slot of the medication bar. The medication bar also had a grey tablet in the evening slots for Tuesday, Wednesday, Thursday, Friday, and Saturday. An additional white tablet was located in the evening slots for Thursday, Friday, and Saturday. R5's punch packs were labeled morning and contained all six medications listed on MAR for morning. R5's noon punch pack listed all three medications listed on MAR for 2pm. R5's Medication Administration Record, dated June 2024, indicated R5 has six medications for morning, three medications scheduled for 2p.m., and two medications for 8p.m.	01770			

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01770	Continued From page 41 R5's medication set up documentation lacked the following required information: - visual description of medication; and - drug classification and special precautions. On June 20, 2024, at 10:53 a.m., CNS-B stated she checks all the medications when completing a medication set up, even the medications that are delivered from the pharmacy in punch packs and this is why they are documented as part of the medication set up. CNS-B stated the medication set up documentation was an error, and the staff would not know which medications are in the punch pack versus the medication bar or what the medications would look like to determine if the correct medications are being administered. CNS-B stated the white tablets missing from the Tuesday and Wednesday 8p.m. slots were an oversight that she has already fixed and the two white tablets in the 2pm slot of the medication bar must have been a refusal and got left in the medication bar and she did not notice them. The licensee's Medication Management-Dosage Box Setup, dated August 1, 2021, indicated a licensed nurse will assure the medication orders are transcribed into the MAR. This profile includes: - dates of medication set up; - medication name; - quantity of dose; - times to be administered; - route of administration; - name of the person completing the medication setup; and - visual description of medication; and drug classification and special procedures. No further information was provided.	01770			

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01770	Continued From page 42	01770			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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 June 17, 2024, at 12:00 p.m., the surveyor was given a binder by the licensed assisted living director (LALD)-A that included facility survey readiness information such as the rosters, facility Tuberculosis risk assessment, staffing plan, quality management meetings, blank contract, resident handbook, and a document titled house rules.	02290			

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02290	Continued From page 43 The resident handbook included a section titled substance abuse and weapons that indicated in order to promote the safety of our residents and staff, the licensee has a strict policy regarding substance abuse and weapons. Residents and employees are not permitted to use or possess alcoholic beverages on company property. You also may not use or possess illegal drugs or controlled substances on licensee's property. Residents may not have or possess any weapon while in this licensee's property or on other licensee's property, to the extent allowed by law. Another section titled receipt of licensee's resident handbook indicated I acknowledge that I have received and have had an opportunity to read a copy of the licensee's resident handbook. I understand that this resident handbook is solely for the purpose of summarizing licensee's current policies, benefits and rules. It included a signature and date section for the resident to sign. The house rules included general house rule: 1. No smoking inside the residence 2. No illegal drugs or alcohol in the residence 3. No theft or property destruction 4. Pets are not allowed. On June 18, 2024, at 11:20 a.m., LALD-A stated the house rules were signed by all the residents at admission and the rules do state no alcohol or illegal substances are allowed at the facility and they would need to remove these rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 06/17/24
Time: 12:00:00
Report: 1025241084

Food and Beverage Establishment Inspection Report

Page 1

Location:

Metro Assisted Living
7663 Jackson Street Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0038078
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128392458
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.

4-300 Equipment Numbers and Capacities

4-301.12C

MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.

Provide a basin for sanitizing food utensils (after wash/rinse with the dishwasher) and use for sanitizing until a dishwasher meeting NSF Standard 184 can be installed.

Comply By: 06/17/24

Food and Equipment Temperatures

Process/Item: Milk

Temperature: 39 Degrees Fahrenheit - Location: Refrigerator

Violation Issued: No

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

Facility has TMD strips for the dishwasher, but the dishwasher was marked with a UL Listed # that does not indicate it meets the requirements of NSF Standard 184 for residential dishwashers. The TMD changing color is likely due therefore to the hi temp dry/steam, which may provide some sanitation but isn't tested/spec'd/rated for the 5 log reduction of actual sanitizing.

Therefore, this dishwasher can be used to wash and rinse dishes, but a separate basin (similar to the one under the sink, although a larger version is probably better) to do a final sanitize step for clean utensils, and allowing utensils to air dry. See information below.

Facility has chlorine test kit and food thermometer.

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Food and Beverage Establishment Inspection Report

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Counter bottom under the sink damaged due to water leak and was reported to be replaced as part of recent service for the leak.

FACILITY

Appliances are residential, laminate countertops, wood cabinets, painted drywall

SINK USAGE

Facility has a two (2) compartment sink

Facility has a dishwasher that has a high temp but does not have a sanitize cycle (see below)

Facility does not have a 3 compartment sink

Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES

Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING – NON ANSI/NSF 184

Dishwasher is not marked with label/data plate indicating it reaches an internal contact temperature necessarily for sanitizing (NSF/ANSI 184: Residential Dishwasher). For information, please search "NSF Residential Dishwashing 184"

As a temporary measure, until a new dishwasher or 3 compartment sink can be installed:

Discussed using the dishwasher to wash and rinse dishes and utensils, and providing a bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:

[...] (5) receptacles that substitute for the compartments of a multicompartment sink.

<https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf>

<https://www.nsf.org/consumer-resources/articles/dishwasher-certification>

EQUIPMENT

MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:

(1) serves only non-TCS food; or

(2) prepares TCS foods only for same-day service.

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Food and Beverage Establishment Inspection Report

Page 3

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS

CFPM (Certified Food Protection Manager)

For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), chemical label, use, and storage, pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)

Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse

Information on food recalls available "MDA Food Recall"

<https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota>

FACT SHEETS

Please search "MDH Fact Sheets" for the Food Business fact sheets page

"Cleaning and Sanitizing" <https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf>

"Food Cooking Temperatures"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf>

"Date Marking TCS foods"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf>

"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs

<https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf>

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 1025241084 of 06/17/24.

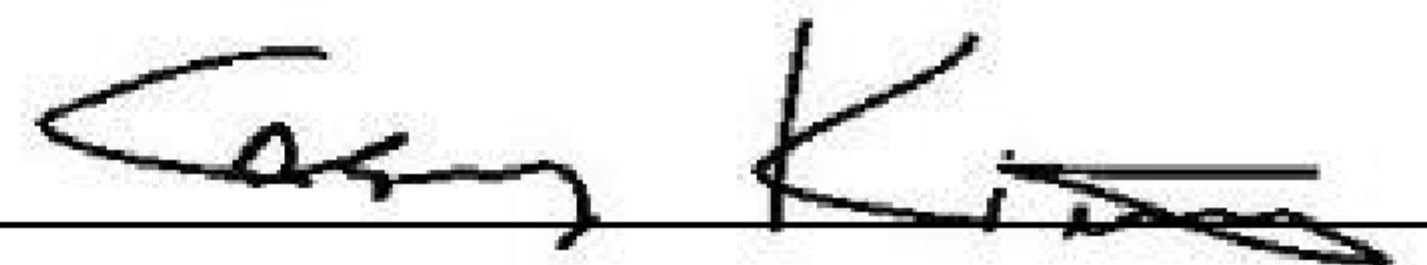
Certified Food Protection Manager Fartun A Abdulkadir

Certification Number: FM114157 Expires: 12/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513

Type: Full
Date: 06/17/24
Time: 12:00:00
Report: 1025241084
Metro Assisted Living

Food and Beverage Establishment Inspection Report

Page 4



casey.kipping@state.mn.us

Report #: 1025241084

m

DEPARTMENT OF HEALTH

Minnesota Department of Health

Division of Environmental Health, FPLS

P.O. Box 64975

St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

0

Date

06/17/24

No. of Repeat RF/PHI Categories Out

0

Time In

12:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Metro Assisted Living

Address

7663 Jackson Street Ne

City/State

Fridley, MN

Zip Code

55432

Telephone

6128392458

License/Permit #

0038078

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in complianceMark "X" in appropriate box for COS and/or RCOS=corrected on-site during inspectionR= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

06/17/24

Inspector (Signature)

