Electronically Delivered
March 1, 2024

Licensee
Angels Homes, LLC
2304 West 150th Street
Burnsville, MN 55306

RE: Project Number(s) SL35485015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 30, 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,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35485	A. BUILDING: _____ B. WING _____	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS HOMES LLC	2304 WEST 150TH STREET BURNSVILLE, MN 55306

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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: SL35485015 On January 29, 2024, through January 30, 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 five residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a working means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 460		

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0 460	Continued From page 2 During the entrance conference on January 29, 2024, at 12:04 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility had a call system in place for residents. On January 29, 2024, at 1:36 p.m. during the facility tour, the surveyor tested the bathroom emergency call light by pressing the button located on the wall next to the toilet. The surveyor did not hear an alarm. The surveyor had LALD/CNS-A show where the receiver box was located, in upstairs living room, plugged into an outlet. The surveyor observed the alarm was not alarming, due to being plugged into an outlet connected to a light switch that was turned off. The surveyor turned on the light switch, retested and found the emergency call light to be of working order. LALD/CNS-A confirmed all the residents had an emergency call button that went through this receiver box, and did not know how long this was not working. On January 29, 2024, at 1:38 p.m. LALD/CNS-A stated the licensee lacked a working system for residents to request assistance for health and safety needs 24 hours a day, seven days a week. LALD/CNS-A stated staff are available to the residents at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 3 (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 ensure the required staffing plan was posted in a central location, potentially affecting the licensee's residents, staff, and any visitors of the licensee. 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	0 470		

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0 470	Continued From page 4 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 29, 2024, at 1:05 p.m. the surveyor observed the common areas of the facility shared by residents, staff and visitors. There was no required posting of the staff schedule observed. On January 29, 2024, at 1:05 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee lacked a posting of the daily staffing schedule. LALD/CNS-A stated the licensee's staff schedule was located at the licensee's other location on a white board, and stated it was not posted at this location. 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 by: Based on observation, interview, and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 5 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 January 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	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	0 650		

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0 650	Continued From page 6 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 one of one employee record (unlicensed personnel (ULP)-B) included the required content. 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: ULP-B's employee record lacked evidence an annual performance review was completed. ULP-B was hired on January 11, 2022, to provide direct care services to the licensee's residents. On January 29, 2024, at 3:56 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B's employee record did not include an annual performance review. LALD/CNS-A further stated it was missed. The licensee's undated, Personnel Records	0 650		

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0 650	Continued From page 7 policy indicated the personnel record for an employee shall include, but not be limited to annual performance evaluation that identifies 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=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment.	0 660		

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0 660	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 29, 2024, at 12:04 p.m. with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, a request was made to review the facility TB risk assessment. On January 29, 2024, at 3:10 p.m. a TB risk assessment dated February 10, 2022, was produced for another location of the licensee. LALD/CNS-A stated the licensee had not completed the annual TB facility risk assessment for this license as indicated in their policy. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The licensee's undated, TB Screening policy indicated the facility will complete a risk assessment worksheet annually and keeps a copy in facility files. No further information was provided.	0 660		

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0 660	Continued From page 9 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 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the	0 680		

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0 680	Continued From page 10 potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on January 29, 2024, at 12:48 p.m. the facility's layout included one building with three resident rooms, kitchen, living room, dining room located on the main level, and two resident rooms, living room located on the lower level. There was no evidence of signage posted or information regarding the licensee's emergency plan. Upon review of the EP plan, provided by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on January 30, 2024, included a one page "[Licensee name]Emergency Planning Guidelines" with a handwritten "revised on January 4, 2022". The emergency planning guide had a header page which included an introduction, preparedness, response and recovery. The plan included an undated Hazard Vulnerability Analysis (HVA), how licensee would coordinate emergency planning for sheltering in place and evacuations, and how licensee would train staff. Other information included procedures for fire, hazmat spill, power outage, tornadoes, snowstorms and extreme cold, and earthquake.	0 680		

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0 680	Continued From page 11 The licensee's plan did not include the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for EP cooperation and collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy;	0 680		

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0 680	Continued From page 12 -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On January 30, 2024, at 3:41 p.m. LALD/CNS-A stated the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's undated, Emergency Disaster Plan Orientation and Training policy indicated the facility will develop an emergency preparedness training program based on the Emergency Disaster Plan, Communication Plan and Emergency Disaster Policies and Procedures. All employees will be orientated to the Emergency Disaster Plan, including their responsibilities in carrying out the plan. This orientation will be provided upon hire (during orientation) and all employees will participate in facility emergency preparedness plan in-service educational sessions annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.	0 690		

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0 690	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two resident service plans (R1, R2) included the date the service plans were completed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included bi-polar disorder and type 2 diabetes. R1's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. R2 R2's diagnoses included bipolar disorder and depression. R2's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. On January 30, 2024, at 10:19 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2's "Daily Service Plan" were undated, stating he missed doing that.	0 690		

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0 690	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are	0 780		

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0 780	Continued From page 15 interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 30, 2024, at 1:20 p.m. with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD/CNS-A tested the smoke alarms and could be heard in the lower level but not in the main level. LALD/CNS-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire	0 790		

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0 790	Continued From page 16 Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 30, 2024, at 1:15 p.m., survey staff conducted a facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, survey staff observed that the fire extinguishers throughout the facility, did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and	0 790		

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0 790	Continued From page 17 remain in working order. LALD/CNS-A stated that they had been doing the annual inspections but did not realize they are required to do monthly inspections. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 800		

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0 800	Continued From page 18 a large portion or all of the residents). Findings include: On January 30, 2024, at 1:15 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, it was observed that two of the emergency exit doors exited out from a family room into the garage and the other one from the dining room out onto a balcony. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. These exit doors were included in the fire safety evacuation plan. Survey staff also observed and verified the following maintenance issues. 1. It was observed that the main level bathroom was missing the caulking around the bottom of the toilet. Also, this bathroom vanity had doors and draws that did not open and shut properly. 2. Lower- level bathroom was missing the fan cover. 3. Lower-level family room had a 3' x 3' hole cut out of the ceiling. LALD/CNS-A stated it was in the process of being repaired from a leak that had occurred in the main-level. 4. Resident bedroom # 1 had the floor full of food, pop and personal items which was blocking the residents access to the egress window. 5. Resident bedroom #2 had the floor full of grocery bags and person items as well as clothes hanging rack which was blocking the egress window and made it impossible to access the resident access to the egress window. 6. Resident bedroom #5 had multiple stains in the carpet.	0 800		

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0 800	Continued From page 19 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be 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	0 810		

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0 810	Continued From page 20 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to 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 January 30, 2024, at 1:30 p.m., license assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the evacuation plan did not have an updated plan to include employee actions to be taken in the event of a fire or similar emergency. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency. Also, the	0 810		

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0 810	Continued From page 21 evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview on January 30, 2024, at 1:30 p.m., LALD/CNS-A verified the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the	0 900		

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0 900	Continued From page 22 contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	0 900		

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0 900	Continued From page 23 (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On January 30, 2024, at 8:47 a.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R2. R2's "Daily Service Plan", undated, indicated services included medication administration, bathing and hygiene reminders. On January 30, 2024, at 3:42 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the service plan was updated; however, a contract had not been developed or implemented for R2. The licensee's undated, Assisted Living Contracts policy indicated that the facility will establish a contract with each client at the time of admission to the program.	0 900		

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0 900	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 910		

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0 910	Continued From page 25 R1's Assisted Living Contract was signed by R1 October 27, 2022. R3's Assisted Living Contract was signed by R3 March 5, 2021. R1 and R3's contract did not include: -health facility identification of the facility. -telephone number, and physical mailing address, which may not be a public or private post office box, of: -the facility and contracted service provider when applicable; -the licensee of the facility; -the managing agent of the facility, if applicable; and -the authorized agent for the facility. On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not aware the contract did not include the requirement listed above. The contract would be the same for all residents and it should have included all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;	0 920		

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0 920	Continued From page 26 (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all required content in the contract for two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Assisted Living Contract was signed by R1 October 27, 2022.	0 920		

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	35485	A. BUILDING: _____ B. WING _____	01/30/2024

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0 920	Continued From page 27 R3's Assisted Living Contract was signed by R3 March 5, 2021 R1 and R3's contract failed to include the following required content: -a delineation of the cost and nature of any other services to be provided for an additional fee; -a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and -a disclosure of the facility's ability to provide specialized diets On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 28 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 950		

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0 950	Continued From page 29 R1 and R3's Assisted Living Contract dated October 27, 2022, and March 5, 2021, lacked the required notice to designate a representative. R1 and R3's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisory (LALD/CNS)-A stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	0 970		

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0 970	Continued From page 30 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The Assisted Living Contract provided included the following clauses which indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Damage of Injury to Resident of Resident's Property, page 10 of the contract, "We are not responsible for any damage or injury suffered by you, your guests or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such	0 970		

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0 970	Continued From page 31 other or additional insurance as Resident considers necessary to protect against injuries and property damage. Out insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property includes but is not limited to dentures, glasses and hearing aids". Acts of Third Parties, page 10 of the contract, "We are not responsible for the actions of, or for any damages, injury or harm caused by the actions of, third parties (such as other residents, guests, intruders or trespassers) who are not under our direct and actual control". Resident's Responsibility for Damages, page 10 of the contract, "You will be responsible for (a) any loss, property damage (including plumbing problems) or cost of repairs or service caused by your use of the Apartment/Room or the Community facilities, normal wear and tear excepted; (b) any loss or damage to the Apartment/Room or the Community facilities caused by doors or windows left open by you or your guests; (c) all costs or losses we incur because of abandonment of the Apartment/Room or other violations of this Agreement by you". Resident's Responsibility for Costs, page 10 and 11 of the contract, "You will be responsible for all costs we incur which are associated in any way with our breach or violation of any of the provisions of this Agreement and with the enforcement of this agreement, including but not limited to costs associated with collection activities and eviction, whether by court action or otherwise, additional staff time, court cost, reasonable attorneys' fees (whether in connection with a court action or not). Such costs shall be	0 970		

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0 970	Continued From page 32 billed to you as additional rent and are subject to the late fees described in paragraph 7. A. of this Agreement." On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated these clauses were included in the contract, and the same contract template is utilized for all residents. The licensee's Assisted Living Contract policy, undated, included the contract must not include a waiver of facility liability for the health and safety or personal property of a resident the contract must not include any provision that the facility knows or should know to be deceptive, unlawful or uncomfortable under state or federal law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 33 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of one employee (unlicensed personnel (ULP)-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: ULP-B was hired on January 1, 2022, to provide direct care and services to the facility's residents. On January 30, 2024, at 8:26 a.m. unlicensed personnel (ULP)-B was observed administering R1's morning medications. ULP-B's employee record contained a background study affiliated with another license owned by the same owner dated January 19, 2022. ULP-B's employee record lacked evidence the licensee affiliated a background study for their license. On January 29, 2024, at 3:49. p.m. licensed	01290		

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01290	Continued From page 34 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B's background study was affiliated with their other location and was not aware of the requirement. The licensee's Personnel Records policy undated, indicated the personnel record would include documentation of background study as required by MN Statute 144.057. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	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	01470		

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01470	Continued From page 35 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) received orientation to assisted living facility licensing requirements and regulations before	01470		

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01470	Continued From page 36 providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 1, 2022, to provide direct care and services to the facility's residents. On January 30, 2024, at 8:47 a.m. the surveyor observed unlicensed personnel (ULP)-B administer R1's medications. ULP-B's employee record did not include the following required orientation content: -an overview of the 144G statues; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -the principles of person-centered planning and service delivery. On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B had not completed	01470		

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01470	Continued From page 37 all components of the required orientation training for assisted living facilities. The licensee's Facility Employee Orientation policy, undated, indicated all employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	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 38 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 ensure one of one employee (unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame. 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 provided services under an Assisted Living license. ULP-B was hired on January 11, 2022, to provide direct care and services to the facility's residents. ULP-B's employee record contained evidence the employee received five hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On January 30, 2024, at 3:41 p.m. licensed	01530		

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01530	Continued From page 39 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B's employee record lacked the required amount of training in dementia care. The licensee's Facility Employee Orientation policy, undated, indicated all employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. 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 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	01620		

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01620	Continued From page 40 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a 90-day comprehensive assessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1's diagnoses included bi-polar disorder and type 2 diabetes. R1's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. R1's last three assessments were requested. R1's "Care Plan Review Assessments" dated June 15, 2023, September 13, 2023, and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35485	A. BUILDING: _____ B. WING _____	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 41 December 18, 2023, were provided, and reviewed by the surveyor on January 30, 2024. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A-N. R2 R2's diagnoses included bipolar disorder and depression. R2's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. R2's last three assessments were requested. R2's "Care Plan Review Assessments" dated June 6, 2023, August 13, 2023, and November 10, 2023, were provided, and reviewed by the surveyor on January 30, 2024. The assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A-N. On January 30, 2024, at 11:50 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the resident's care plan was reviewed every 90 days and he would write a note if there was a change in the service plan. LALD/CNS-A reviewed the criteria for the Uniform Assessment Tool and stated their 90-day assessments did not contain the required content for any of the residents. The licensee's Nursing Assessment and Reassessment of Residents policy, undated, indicated the RN would conduct a comprehensive assessment upon admission and reviewed and revised every 90 days and the assessment would	01620		

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01620	Continued From page 42 include but not limited to the requirements outlined in MN Rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included bi-polar disorder and type 2 diabetes. On January 30, 2024, at 8:26 a.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R1. R1's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. However, the service plan lacked the frequency of each service, according to the resident's current assessment and resident preferences. R2 R2's diagnoses included bipolar disorder and depression.	01650		

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01650	Continued From page 44 On January 30, 2024, at 8:47 a.m. ULP-B was observed to administer oral medications to R2. R2's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. However, the service plan lacked the frequency of each service, according to the resident's current assessment and resident preferences. On January 30, 2024, at 11:30 a.m. unlicensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2's "Daily Service Plan" did not include the information listed above. LALD/CNS-A stated they had 'missed this.' The licensee's Service Plan policy, undated, indicated the service plan would include the type and frequency of visits/services proposed to be furnished according to the resident's current review/assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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	35485	A. BUILDING: _____ B. WING _____	01/30/2024

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01730	Continued From page 45 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1, R2).	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 46 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 began receiving assisted living services on October 27, 2022. On January 30, 2024, at 8:26 a.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R1. R1's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. R2 R2 began receiving assisted living services on August 1, 2021. On January 30, 2024, at 8:47 a.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R2. R2's "Daily Service Plan", undated, indicated services included medication administration, bathing, and hygiene reminders. R1 and R2's record lacked a medication management plan to include the procedures for staff notifying a registered nurse or appropriate	01730		

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01730	Continued From page 47 licensed health professional when a problem arises with medication management services. On January 30, 2023, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated being unaware the medication management plan was missing the above information. The licensee's Individualized Mediation Management Plan and Record policy, undated, indicated the plan would include procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 48 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 30, 2024, at 8:50 a.m. the locked medication cart was reviewed with unlicensed personnel (ULP)-B. The following expired medication for R1 was observed and confirmed with ULP-B: - Nitroglycerin sublingual 0.3 milligrams (mg) had an expiration date of November 1, 2023. On January 30, 2024, at 3:41 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the medication above was expired, and that R1 does not use the medication regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *01/29/24*
Time: 13:41:29
Report: 7994241014

Food and Beverage Establishment Inspection Report

Location:

Angels Homes Llc
2304 West 150th Street
Burnsville, MN55306
Dakota County, 19

Establishment Info:

ID #: 0039045
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522121688
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

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

FACILITY CURRENTLY DOES NOT HAVE AN APPROVED TEMPERATURE MEASURING DEVICE. SPOKE WITH MANAGER ABOUT VARIOUS OPTIONS TO TEST DISHWASHER TEMP.

Comply By: 01/29/24

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM WAS FOUND ON SITE. POST CFPM ON SITE.

Comply By: 01/29/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

A FEW DOORS ARE MISSING FROM CABINETS. A WORK PLAN IS ALREADY IN PLACE TO FIX THEM.

Comply By: 01/29/24

Type: Full
Date: *01/29/24*
Time: 13:41:29
Report: 7994241014
Angels Homes Llc

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS WOOD LAMINATE TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241014 of 01/29/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us