



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 22, 2024

Licensee
Arden Homes LLC
1013 West River Road
Champlin, MN 55316

RE: Project Number(s) SL36314015

Dear Licensee:

On July 23, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 7, 2024, survey were corrected. This follow-up survey verified that the immediate correction order issued for tag identification number 2310 was corrected.

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 blue ink, appearing to read 'Jess'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/23/2024
NAME OF PROVIDER OR SUPPLIER ARDEN HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 WEST RIVER ROAD CHAMPLIN, MN 55316		
(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: SL36314015-1 On July 22, 2024 through July 24, 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 6, 2024. At the time of the survey, there were four residents receiving services under the Assisted Living license. As a result of the follow-up survey, the citation with tag identification 2310 was corrected.	{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.		
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{0 100}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 100}	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	{0 100}			

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{0 100}	Continued From page 2	{0 100}			
{0 470} SS=F	This MN Requirement is not met as evidenced by: Citation not reviewed at this follow up visit. Awaiting provider decision after informal conference held July 18, 2024. 144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	{0 470}			

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{0 470}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required	{0 470}			
{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: No further action required	{0 550}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: No further action required	{0 570}			

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{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 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}			
{0 680} 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	{0 680}			

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{0 680}	Continued From page 5 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}			
{0 780} 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	{0 780}			

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{0 780}	Continued From page 6 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: No further action required	{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 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: No further action required	{0 790}			

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{0 800}	Continued From page 7	{0 800}			
{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: 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.	{0 810}			

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{0 810}	Continued From page 8 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: No further action required	{0 820}			

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{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 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: No further action required	{0 970}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	{01060}			

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{01060}	Continued From page 10 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required	{01060}			
{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	{01620}			

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{01620}	Continued From page 11 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required	{01620}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	{01640}			

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{01640}	Continued From page 12 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required	{01640}			
{01730} SS=D	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: (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	{01730}			

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{01730}	Continued From page 13 (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: No further action required	{01730}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/23/2024
NAME OF PROVIDER OR SUPPLIER ARDEN HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 WEST RIVER ROAD CHAMPLIN, MN 55316		
(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	
{01890} SS=F	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: No further action required	{01890}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/23/2024
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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
{01940}	Continued From page 15 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required	{01940}			



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

July 3, 2024

Licensee
Arden Homes LLC
1013 West River Road
Champlin, MN 55316

RE: Project Number(s) SL36314015

Dear Licensee:

Please note: This letter amends the previous letter dated July 2, 2024. Specifically, the Informal Conference numerical calendar date has been corrected to on or before Wednesday, July 10, 2024. No to other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on June 7, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

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

§ 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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 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>

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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Arden Homes LLC. Please contact Jess Schoenecker, Supervisor at 651-201-3789 **on or before Wednesday, July 10, 2024**, to schedule the conference call.

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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 2, 2024

Licensee
Arden Homes LLC
1013 West River Road
Champlin, MN 55316

RE: Project Number(s) SL36314015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 7, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

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In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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 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>

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:

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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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Arden Homes LLC. Please contact Jess Schoenecker, Supervisor at 651-201-3789 **on or before Wednesday, July 12, 2024**, to schedule the conference call.

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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER ARDEN HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 WEST RIVER ROAD CHAMPLIN, MN 55316		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36314015-0 On June 4, 2024, through June 6, 2024, the Minnesota Department of Health conducted an initial 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 provider's provisional Assisted Living license. On June 5, 2024, an immediate correction order was issued for tag identification number 2310. The immediacy of the order remained in place at the time of exit on June 6, 2024.	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.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/07/2024
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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2024
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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to obtain accurate licensure when they applied for licensure for a single residential dwelling, despite sharing one roof with an adjoining townhome, without having an approved two-hour fire separation between the two dwellings. 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 June 4, 2024, at 8:45 a.m., the surveyor toured the home with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. During the tour, the surveyor observed the assisted living licensed facility was located in a building with two connected dwellings units, sharing the same roof, with separate entrances and separate addresses. The address for the assisted living facility was 1013 West River Road, Champlin, Minnesota (MN) 55316. The address for the dwelling unit connected to the assisted living facility was 1017 West River Road, Champlin, MN 55316. During the exit conference on June 6, 2024, at 2:30 p.m., LALD/CNS-C stated building plans	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2024
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0 100	Continued From page 3 were not available showing there was a two-hour fire separation between the assisted living facility and the attached dwelling unit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2024
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0 470	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation and interview, licensee failed to ensure the required 24-hour staffing schedule was posted 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 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 June 4, 2024, at 9:58 a.m., during the facility tour, the surveyor observed a blank white laminated paper used for posting the staffing schedule in a central location. On June 4, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C was observed filling in the staffing schedule for June 4, 2024, on a white laminated paper used for posting the staffing schedule in a central location. The paper did not have the 24-hour staffing schedule. On June 4, 2024, at 10:43 a.m., LALD/CNS-C acknowledged the licensee was not aware of 24-hour staffing schedule had to be posted for residents, staff, and visitors to be able to access in common area. LALD/CNS-C stated the licensee would correct going forward.	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2024
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0 470	Continued From page 5 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
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 and interview, the licensee failed to ensure the Offices of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OOMHDD), Minnesota Adult Abuse Reporting Center (MAARC), and contact information for the individual(s) who were responsible for handling resident grievances was posted in a conspicuous place as required. This had the potential to affect all the licensee's current residents, staff, and	0 550			

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NAME OF PROVIDER OR SUPPLIER ARDEN HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1013 WEST RIVER ROAD CHAMPLIN, MN 55316			
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0 550	Continued From page 6 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 a facility tour on June 4, 2024, at 9:58 a.m., the surveyor observed the common areas shared by residents, staff, and visitors, had the licensee's 2.09 Complaint/Grievance policy dated August 1, 2024, posted but lacked the required posting of the OOLTC, OOMHDD, MAARC, and contact information for the individual(s) who were responsible for handling resident grievances. On June 4, 2024, at 1:19 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee consulted with the licensee's consultant and received a new posting that included all the required information for the complaint process, MAARC reporting, and the Ombudsman information. The licensee's 2.10 Complaint/Grievance Posting policy dated March 16, 2023, indicated, "[Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." Also, the policy indicated the posting will have the contact information for	0 550			

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0 550	Continued From page 7 OOLTC, OOMHDD and MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. 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: During a facility tour on June 4, 2024, at 9:58 a.m., the surveyor did not observe a posting of the original current license at the facility's main entrance. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had recently received the new license and had not posted it yet.	0 570			

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0 570	Continued From page 8 On June 4, 2024, at 10:14 a.m., LALD/CNS-C was observed posting the new original current license at the main entrance. The licensee's 2.04 Assisted Living License and Posting policy dated August 1, 2021, indicated the original current license shall be displayed at the main entrance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
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 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	0 650			

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0 650	Continued From page 9 (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 for one of two employees (licensed practical nurse (LPN)-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) 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: LPN-B was hired on July 1, 2022. LPN-B's employee record lacked evidence of completed annual performance reviews. On June 4, 2024, at 12:27 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee missed and annual performance review for LPN-B as an oversight of licensee. On June 4, 2024, at 12:31 p.m., LALD/CNS-C was observed by surveyor, initiating an annual performance review form, and then stated they would have LPN-B sign the form. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would include documentation of annual	0 650			

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0 650	Continued From page 10 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			
0 680 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:	0 680			

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0 680	Continued From page 11 Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency preparedness plan lacked evidence of the following required content: - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program; - policy and procedure to address food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy whether evacuated or sheltered in place for staff and residents; - policy and procedure to address alternate sources of energy to maintain temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration;	0 680			

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0 680	Continued From page 12 - policy and procedure to address role of facility under a waiver declared by the Secretary; - Communication plan that included primary and alternate means of communicating with facility staff and Federal, State, tribal, regional & local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information from the emergency plan with residents and their families/representatives; and - emergency prep testing requirements that included analyses of the facility's response to all drills, tabletop exercises and emergency events & revised plan as needed. On June 6, 2024, at 12:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C, indicated the licensee was not aware the emergency preparedness binder did not have all the required content. LALD/CNS-C indicated the licensee had extra batteries and food but did not have an emergency bag on the premise of the facility. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780			

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0 780	Continued From page 13 (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 outside some sleeping rooms in the facility. 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	0 780			

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0 780	Continued From page 14 or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 4, 2024, at approximately 9:00 a.m. with the license assisted living director/clinical nurse supervisor (LALD/CNS)-C, the surveyor noted the smoke alarm inside of guest bedroom #2 was not present. The surveyor explained to the LALD/CNS-C, that all bedrooms and rooms outside the bedrooms in a state-licensed facility shall have a smoke alarm present and they must be interconnected. During a facility tour on June 4, 2024, at 10:00 a.m., the LALD/CNS-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) 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 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	0 790			

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0 790	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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) 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 June 4, 2024, at approximately 9:00 a.m. with the license assisted living director/clinical nurse supervisor (LALD/CNS)-C, the surveyor noted the required fire extinguisher on the main level was not mounted. The surveyor explained to LALD/CNS-C that fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During a facility tour on June 4, 2024, at 10:00 a.m., the LALD/CNS-C, verified the above listed observations while accompanying on the tour.	0 790			

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0 790	Continued From page 16	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's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 June 4, 2024, at approximately 9:00 a.m. with the license assisted	0 800			

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0 800	Continued From page 17 living director/clinical nurse supervisor (LALD/CNS)-C, the surveyor noted an electrical wire that was not in the wall and entered an electrical box behind the clothes washer under the receptacle cover. The surveyor explained to LALD/CNS-C, that all electrical installation in a state-licensed facility must meet the electrical code. It was observed that the white electrical cord feeding the chair lift was routed through the office door. Electrical cords shall be used per the manufacture instructions and they shall not be routed through doors/walls. During the tour, survey staff noticed the bathroom fan in the lower level was not working. During a facility tour on June 4, 2024, at 10:00 a.m., the LALD/CNS-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810			

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0 810	Continued From page 18 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required training and drills for residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 19 Findings include: A record review and interview were conducted on June 4, 2024, at approximately 10:00 a.m. with the license assisted living director/clinical nurse supervisor (LALD/CNS)-C on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. Record review indicated the licensee failed to provided fire safety and evacuation training to employees upon hire and at least twice per year thereafter. During the tour, the surveyor noted there were no evacuation maps posted in the facility. Fire safety and evacuation plans shall be readily available at all times within the facility. Record review indicated the licensee failed to document properly evacuation drills twice per year per shift with at least one evacuation drill per month. No employee signatures were noted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820			

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0 820	Continued From page 20 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). Findings include: On a facility tour on June 4, 2024, at approximately 9:00 a.m. with the license assisted living director/clinical nurse supervisor (LALD/CNS)-C, the surveyor noted cigarette butts on the ground next to the deck. The surveyor explained to LALD/CNS-C, that all cigarette butts shall be properly discarded into an approved container. During a facility tour on June 4, 2024, at 10:00 a.m., the LALD/CNS-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820			

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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 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 that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all 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 potential to affect a large portion or all the residents). The findings include: On June 5, 2024, at 8:39 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the surveyor with a blank contract and stated the same contract was used for all licensee's residents. The licensee's undated Resident Agreement indicated under section, Indemnification, "the	0 970			

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0 970	Continued From page 22 resident will indemnify and hold harmless landlord, its employees, and agents from and against any and all claims, actions, damages to property, arising from or out of the use by resident of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of resident or residents guest or agents." On June 6, 2024, during the exit conference at 2:30 p.m., LALD/CNS-C stated the licensee was not aware of the waiver of liability in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060			

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01060	Continued From page 23 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01060			

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01060	Continued From page 24 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: R1 was admitted on March 29, 2023. R1's medical record indicated R1 was sent to the emergency room on the following dates: January 4, 2024, January 12, 2024, and March 8, 2024. R1's medical record indicated R1 was hospitalized less than four days from March 8, 2024, through March 11, 2024. R1's medical record indicated R1 was hospitalized greater than four days on January 18, 2024, through January 28, 2024. R1's record lacked documentation the resident or designated representative was provided a written notice with the required content when emergently relocated and lacked documentation the OOLTC was provided a written notification when R1 did not return to the facility within four days. On June 5, 2024, at 1:26 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware of the emergency relocation notice and calling the Ombudsman if a resident did not return within four days, however they were not aware that this included hospitalizations. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated a written notice with the required content would be provided to the resident in the case of an emergency relocation;	01060			

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01060	Continued From page 25 and the facility would notify the OOLTC if the resident had been relocated and did not return to the facility within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
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 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

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01620	Continued From page 26 Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for two of two residents (R1, R2). Also, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment 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 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 was admitted on March 29, 2023. R1's Hennepin County Disability Waiver Rate Management System Provider Worksheet for Customized Living dated April 1, 2024, through March 31, 2025, was indicated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as R1's service plan indicated R1 received the following services: assistance with dressing, grooming, bathing, continence care, positioning, eating, walking, transfers, medication homemaking, shopping, meal preparations, appointments, non-medical transportation, and socialization.	01620			

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01620	Continued From page 27 R1's Uniform Assessment Tool initially dated March 29, 2023, indicated a 14-day assessment was completed on April 12, 2023, and 90-day assessments completed on June 28, 2023, September 25, 2023, January 4, 2024, and April 22, 2024. R1's subsequent 14-day and 90-day assessments failed to address the required content per Minnesota Administrative Rule 4659.0150. R1's Uniform Assessment Tool initially dated March 29, 2023, indicated a 90-day assessment was completed on September 25, 2023, with the next 90-day assessment completed 101 days later, on January 4, 2024; the next 90-day assessment was completed 109 days later, on April 22, 2024. These assessments failed to ensure the RN conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment. R2 R2 was admitted on September 14, 2023. R2's 24-Hour Customized Living Home Health Aide Care Plan last dated on March 14, 2024, indicated R2 received the following services: assistance with dressing, grooming, bathing, meal preparation, exercise program, ambulation, socialization, behavior/orientation, medication assistance, vital sign monitoring, safety checks, transportation, and mental health treatment. R2's Uniform Assessment Tool initially dated September 14, 2023, indicated a 14-day assessment was completed on September 27, 2023, and 90-day assessments completed on December 13, 2023, and March 14, 2024. R2's subsequent 14-day and 90-day assessments failed to address the required content per	01620			

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01620	Continued From page 28 Minnesota Administrative Rule 4659.0150. R2's Nurse Reassessment Visit form dated January 5, 2024, indicated visit was for a follow up; and on March 16, 2024, for a 90-day visit, failed to address the required content per Minnesota Administrative Rule 4659.0150. On June 5, 2024, at 11:15 a.m., LALD/CNS-C indicated the 14-day, 90-day, and change in condition assessments were documented at the end of the initial Uniform Assessment Tool form for all residents and licensee was not aware of the required content per Minnesota Rule for all subsequent assessments following the initial assessment. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, included assessment schedule with appropriate timing, and indicated the individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person, be in writing, dated and signed by the registered nurse who conducted the individualized review but failed to identify all areas to be assessed as required per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool	01620			

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01620	Continued From page 29 to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan contained all the required content and failed	01640			

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01640	Continued From page 30 to ensure the current service plan included a signature or other authentication by the licensee and by the resident or resident's representative to document agreement of services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted on March 29, 2023. On June 5, 2024, at 10:25 a.m., surveyor observed LPN-B provide meal preparation for R1. R1's Hennepin County Disability Waiver Rate Management System Provider Worksheet for Customized Living dated April 1, 2024, through March 31, 2025, was indicated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as R1's service plan. R1's record lacked a signed service plan with all the required content. R2 R2 was admitted on September 14, 2023. On June 5, 2024, at 10:11 a.m., surveyor observed LPN-B provide medication assistance for R2. R2's 24-Hour Customized Living Home Health	01640			

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01640	Continued From page 31 Aide Care Plan last dated on March 14, 2024, was indicated by LALD/CNS-C as R2's service plan. R2's record lacked a signed service plan with all the required content. R3 R3 was admitted on December 29, 2023. R3's Customized Living Rates Worksheet dated January 5, 2024, was indicated by LALD/CNS-C as R3's service plan. R3's record lacked a signed service plan with all the required content. On June 5, 2024, at 11:06 a.m., LALD/CNS-C stated the residents only sign the contracts and do not sign the service plans, however this was an oversight as she thought the contract was sufficient. LALD/CNS-C indicated the licensee was using a different form previously which included all the required content and a space for signature or other authentication by the licensee and resident or resident's representative to document agreement of services. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services will have a service plan in place. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730			

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01730	Continued From page 32 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: (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.	01730			

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01730	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on March 29, 2023. R1's Hennepin County Disability Waiver Rate Management System Provider Worksheet for Customized Living dated April 1, 2024, through March 31, 2025, indicated R1 received medication management services. R1's record lacked a service plan. R1's Uniform Assessment Tool dated March 29, 2023, indicated R1 was "deemed unable to safely self-administer medications." No other assessment information on medication management was documented on the assessment. R1's subsequent assessments on April 12, 2023, June 28, 2023, September 25, 2023, January 4, 2024, and April 22, 2024, did not indicate additional information on R1's medication management services.	01730			

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NAME OF PROVIDER OR SUPPLIER ARDEN HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 WEST RIVER ROAD CHAMPLIN, MN 55316		
(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
01730	Continued From page 34 R1's record lacked an individual medication management plan with all required content, additionally, the licensee failed to develop a service plan which indicated R1 received medication management services. On June 6, 2024, at 12:21 p.m., LALD/CNS-C stated the individualized medication management plan should have been in the record. The licensee's 7.03 Medication Management Individualized Plan policy, dated August 1, 2021, indicated licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment and would include all required content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760			

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01760	Continued From page 35 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on September 14, 2023. On June 5, 2024, at 10:11 a.m., the surveyor observed licensed practical nurse (LPN)-B provide medication assistance for R2. The surveyor observed a sticky note on R2's Medication Administration Record (MAR) for the month of June indicating not to administer risperidone. R2's 24-Hour Customized Living Home Health Aide Care Plan last dated on March 14, 2024, indicated R2 received medication assistance. R2's record lacked a signed service plan.	01760			

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01760	Continued From page 36 R2's physician order signed January 5, 2024, indicated R2 was prescribed Risperidone 2 milligrams (mg) tablet take one tab bedtime for psychosis for a quantity of fifteen tablets. R2's MAR dated April 1, 2024, through April 30, 2024, indicated risperidone 2 mg tablet 2 take one tablet by mouth at bedtime for psychosis dated January 5, 2024. The MAR lacked documentation of administration of risperidone after April 24, 2024, and had written "waiting for D/C [discontinue] verification from MD [medical doctor]." R2's MAR dated May 1, 2024, through May 31, 2024, indicated risperidone 2 mg tablet 2 take one tablet by mouth at bedtime for psychosis dated January 5, 2024. The MAR lacked documentation of administration of risperidone for the month of May. R2's Nursing Notes dated March 13, 2024, through June 5, 2024, lacked documentation of follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed until June 4, 2024, which indicated risperidone was not available and pharmacy had indicated they needed a new prescription before refilling the medication. On June 6, 2024, at 1:09 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated LPN-B called the pharmacy on June 5, 2024, as R2's primary provider would not give an order to discontinue since that provider did not prescribe risperidone. LALD/CNS-C stated they were not aware of any staff contacting the prescribing provider and did not know why follow up had not been done	01760			

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01760	Continued From page 37 previously when medication was not administered as ordered. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated if medication assistance and/or administration were not completed as prescribed, documentation would include the reason why it was not completed and any follow up procedures that were completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=F	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 expired medications were disposed of for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01890			

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01890	Continued From page 38 or has the potential to affect a large portion or all of the residents). The findings include: On June 4, 2024, at 10:14 a.m., the surveyor observed the licensee's medication cart. The surveyor observed the following expired medications: R1 - ketoconazole 2% shampoo apply topically to scalp daily as needed expired May 7, 2024; - Trueplus Glucose On The Go 4 gram (g) chewable tablet chew and swallow four tablets (16 g) by mouth once as needed for up to one dose expired on March 26, 2024; - Two containers of bacitracin expired April 2024 and February 2024; - mupirocin ointment 2% expired on January 2024; - ibuprofen 600 milligrams (mg) tablets take one tablet by mouth every eight hours as needed for pain expired April 5, 2024; - Narcan 4 mg/0.1 milliliter (ml) nasal spray place one spray (4 mg) into one nostril as needed expired March 26, 2024; and - phenazopyridine tablet 200 mg take one tablet by mouth three times daily as needed for pain for up to five days expired May 7, 2024. R4 - tizanidine tablet 2 mg take one tablet by mouth every six hours as needed for muscle spasm expired on December 20, 2023; - naproxen tablet 500 mg take one tablet by mouth every 12 hours as needed for pain expired on December 20, 2023; and - two cards of senexon-s tablet 8.6-50 mg take one tablet by mouth twice daily as needed for constipation expired January 11, 2024.	01890			

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01890	Continued From page 39 On June 4, 2024, at 10:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated the residents typically did not use their as needed medications but the nurse should be going thru the medication cart. LALD/CNS-C indicated the licensee would destroy the expired medications. The licensee's Medication Disposal policy dated August 1, 2021, indicated expired medications managed by licensee will be disposed of according to the accepted practices of the Minnesota Board of Pharmacy and the labels from the containers will be destroyed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940			

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01940	Continued From page 40 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan with all 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) 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: R1 R1 was admitted on March 29, 2023. R1's Hennepin County Disability Waiver Rate Management System Provider Worksheet for Customized Living dated April 1, 2024, through March 31, 2025, indicated R1 received daily	01940			

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01940	Continued From page 41 blood glucose monitoring. R1's record lacked a signed service plan. R1's Uniform Assessment Tool dated March 29, 2023, indicated under endocrine section, R1 needed assistance with blood glucose monitoring but resident declined assistance. The treatment section on the assessment was blank. R1's subsequent assessments on April 12, 2023, June 28, 2023, September 25, 2023, January 4, 2024, and April 22, 2024, did not indicate additional information on R1's treatment management services. R1's Diabetic Flow Sheet dated June 2024, indicated R1 had blood glucose monitoring before breakfast, lunch, and dinner with results documented. R1's record lacked an individual treatment management plan with all required content, additionally the licensee failed to develop a service plan which indicated R1 received blood glucose monitoring. R2 R2 was admitted on September 14, 2023. R2's record lacked a signed service plan. R2's provider ordered graduated compression stockings for diagnosis of lymphedema (swelling) of both lower extremities. R2's Individualized Treatment or Therapy Management Plan (ITTMP) dated September 14, 2023, indicated R2 received a treatment for vital signs. R2's record did not have vital signs ordered by R2's provider. R2's ITTMP lacked a treatment	01940			

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01940	Continued From page 42 for graduated compression stockings as ordered by R2's provider. In addition, the licensee failed to develop a service plan which indicated R1 received a treatment for compression stocking. On June 6, 2024, at 12:21 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C indicated the licensee was aware of the required content for individualized treatment or therapy management plans. LALD/CNS-C stated the individualized treatment or therapy management plan for R1 should have been in the record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R3) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	02310			

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02310	Continued From page 43 or a violation that has the potential to lead to 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 On June 5, 2024, at 9:17 a.m., surveyor observed R1's bed was noted to have hospital style bed rails attached on the upper left side of bed on the opposite side of the wall. Bed rails were grabbed by surveyor and bed rails appeared to be very loose when surveyor pushed and pulled on them. On June 5, 2024, at 9:49 a.m., observed R1 sitting on side of hospital bed and holding on to bedrail for support. R1 stated they needed the bed rails to assist them with all transfers. R1 stated the bedrails have been loose for the last 3 months. R1 reported staff was aware and can see the bed rail is loose when they provide cares. R1 was admitted on March 29, 2023, with diagnoses of diabetes, multiple sclerosis, major depression, chronic obstructive pulmonary disease, obesity, and seizure disorder. R1's Individual Abuse Prevention Plan dated March 30, 2023, indicated R1 had a vulnerability with side rails/bed mobility. The interventions included safety checks of side rail/bed positioning device every shift when in use; and staff to report concerns with side rails/bed positioning device to nurse promptly. R1's Side-Rail Use Assessment dated March 29, 2023, indicated R1 used bed rail to assist getting	02310			

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02310	Continued From page 44 in or out of bed and to assist with repositioning in bed. R1's medical record lacked: - documentation of measurements of zones of entrapment; - indication if the side rails were Food and Drug Administration (FDA) compliant; and - documentation risk verses benefits were discussed with R1 or R1's responsible party. R3 R3 was admitted on December 29, 2023, with diagnoses of an intraabdominal organ injury (new paraplegic) due to a gunshot wound, abdominal wall contusion, rib fracture, lumbar fracture, lacerated kidney, post-traumatic stress disorder, anxiety, and depression. R3's Individual Abuse Prevention Plan dated January 2, 2024, indicated R3 had a vulnerability with side rails/bed mobility. R3's assessment lacked interventions. R3's goal/outcome indicated the side rail was used consistent with the manufacturer's directions; the side rails were installed securely and maintained in good operating condition; and the side rail design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. R3's Side-Rail Use Assessment dated January 2, 2024, indicated R3 used bedrails (side rails) to assist getting in or out of bed and to assist with repositioning in bed. R3's medical record lacked: - documentation of measurements of zones of entrapment; - indication if the side rails were Food and Drug	02310			

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02310	Continued From page 45 Administration (FDA) compliant; and - documentation risk verses benefits were discussed with R3 or R3's responsible party. On June 5, 2024, at 9:43 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware of all the requirements for bed rails. LALD/CNS-C stated licensee had not completed measurements, ensured the bed rails were FDA compliant, discussed risk versus benefits with the resident, and documented those actions and responses. On June 5, 2024, at 9:54 a.m., LALD/CNS-C stated they were aware of the loose bed rail during the last time they were at the facility on May 19, 2024, as they assisted R1 into bed. LALD/CNS-C stated they had reached out to the durable medical supply store but did not have it documented and no further follow up was completed. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment	02310			

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02310	Continued From page 46 zone. The licensee's 6.28 Side rails policy dated August 1, 2021, indicated licensee would ensure rails were FDA compliant, measurements were within the FDA's guidelines, and risk versus benefits would be discussed and documented in the resident's record. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently-Asked Questions (FAQs) website accessed on March 20, 2023, at 9:33 a.m., read under Hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order remained in place at the time of exit on June 6, 2024.	02310			

Type: Full
Date: 06/04/24
Time: 11:00:00
Report: 8087241135

Food and Beverage Establishment Inspection Report

Page 1

Location:

Arden Homes LLC
1013 West River Road
Champlin, MN55316
Hennepin County, 27

Establishment Info:

ID #: 0039114
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122292761
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 2 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR RHAWNIE QUINEHAN.

FLOORS AND CABINETS ARE HARDWOOD AND POPCORN CEILING IS NOT DURABLE, SMOOTH IN TEXTURE OR EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE

Type: Full
Date: 06/04/24
Time: 11:00:00
Report: 8087241135
Arden Homes LLC

Food and Beverage Establishment Inspection Report

Page 2

FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

FRIGIDARE BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION AS SHOWN BY TEMPERATURE STRIP LOG ON SITE.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IS RIGHT SIDE OF 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR RHAWNIE QUINEHAN.

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 8087241135 of 06/04/24.

Certified Food Protection Manager GOTOMO S. GORDON

Certification Number: FM122728 Expires: 04/22/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

GOTOMO S. GORDON
MANAGER

Signed: _____

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