Electronically Delivered

September 7, 2023

Licensee
Totalcare Assisted Living Southeast
2730 Winnetka Avenue North
New Hope, MN 55428

RE: Project Number(s) SL25459015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 10, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The 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. The 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

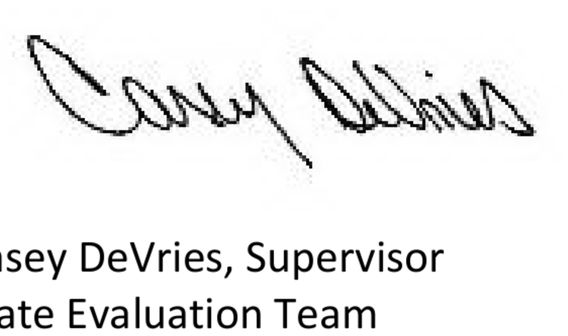
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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: SL25459015-0 On August 7, 2023, through August 10, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 residents, all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 7, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control three of four residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 8, 2023, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-E perform a blood pressure check on R2 in the nursing office without cleaning the blood pressure cuff before or after use. On August 8, 2023, 7:36 a.m., the surveyor observed ULP-E perform a blood pressure check on R3 in the nursing office. ULP-E used the same blood pressure cuff used on R2 without cleaning the blood pressure cuff before or after use. In	0 510		

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0 510	Continued From page 3 addition, the surveyor observed ULP-E perform blood glucose monitoring with use of a shared reusable spring-loaded trigger lancet device. ULP-E removed the lancet from the device and cleaned the outside of the device with hand sanitizer and a cotton ball. On August 8, 2023, at 7:59 a.m., the surveyor observed ULP-E perform a blood pressure check on R4 in the nursing office. ULP-E used the same blood pressure cuff used on R2 and R3 without cleaning the blood pressure cuff before or after use. On August 8, 2023, at 8:32 a.m., ULP-E stated they clean all shared medical equipment when they arrived to work and between residents with alcohol wipes or hand sanitizer and cotton balls. The surveyor inquired why they did not clean the blood pressure cuff between residents. ULP-E stated they normally do however, they were unsure why they did not do that today. The surveyor inquired if they utilized the shared reusable lancet device on different residents. ULP-E stated yes, because R3 did not have supplies left and they used the licensee's backup supplies. ULP-E stated the licensee normally supplied Clorox wipes to clean medical equipment but were currently out of them in the office, and the residents complained about the bleach smell from the wipes. On August 8, 2023, at 8:43 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to clean off medical equipment and surfaces in-between residents. The surveyor inquired what they trained ULP to use to sanitize equipment. CNS-C stated they used Clorox wipes. The surveyor inquired if they had a supply of Clorox wipes. CNS-C stated yes however, the ULP	0 510		

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0 510	Continued From page 4 would have needed to restock the nursing office. CNS-C then showed the surveyor the sanitizing wipes the licensee had on hand. The surveyor inquired if they used a shared reusable spring-loaded trigger lancet device for blood glucose. CNS-C stated they did in case of emergency when residents did not have a personal supply left and the equipment they had depended on the licensee's budget. A document from the CDC website titled Disinfection and Sterilization dated May 24, 2019, recommended to perform low-level disinfection for noncritical patient-care surfaces and equipment that touch intact skin. A document from the CDC website titled Clinical Reminder: Use of Finger Stick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens dated August 23, 2010, recommended reusable devices that resemble a pen and have the means to remove and replace the lancet after each use should never be used for more than one person. The licensee's Infection Control policy, dated August 1, 2021, indicated equipment used for resident care would be properly cleaned and reprocessed. In addition, the licensee would observe the recommended precautions for home care [assisted living] as identified by the CDC, OSHA regulations, current law, and accepted health care, medical and nursing standards for infection control. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 630	Continued From page 5	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content 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 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 admitted for assisted living services on July 27, 2022. R1's diagnoses included paranoid type	0 630		

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0 630	Continued From page 6 schizophrenia (a mental disorder with symptoms of hallucinations, delusions, and disorganized thinking), diabetes, hypertension, hyperlipidemia (high cholesterol), and repeated falls. R1's Service Plan (Waiver)- Addendum to Contract signed March 14, 2023, indicated R1 received assistance with activities, appointment assistance, bathing reminders, continuous positive airway pressure (CPAP), grooming reminders, housekeeping, laundry, behavior management, meals, medication administration, blood glucose monitoring, vital sign monitoring, safety checks, and shopping assistance. R1's IAPP dated July 16, 2023, indicated R1 was at risk to be abused by others and was not at risk to abuse other vulnerable adults, however, did not include the required: - statements of the specific measures to be taken to minimize the risk of abuse to that person. On August 9, 2023, at 9:21 a.m., clinical nurse supervisor (CNS)-C stated they complete a risk of vulnerability assessment on all residents to assist in developing a plan to decrease the risk of vulnerability. In addition, CNS-C stated once the risk assessment was complete it should auto populate into a plan that would generate interventions to minimize the risk of abuse. The surveyor inquired why R1's IAPP did not include interventions to minimize the risk of abuse. CNS-C stated, "I am not sure why, it cut short. As you can see, I have it under all the other ones." The licensee's Vulnerable Adult policy dated August 1, 2021, indicated in compliance with Minnesota Statutes, all assisted living service employees were required to individually assess residents to determine vulnerability to abuse or	0 630		

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0 630	Continued From page 7 neglect and develop a specific plan to minimize the risk of abuse to that resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650		

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0 650	Continued From page 8 records contained the required content for two of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-C CNS-C began employment with the licensee on January 20, 2022, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked documentation for the following required annual training topics: - reporting maltreatment; - assisted living bill of rights; - infection control techniques; - review of providers policies and procedures; and - principles of person-centered planning. ULP-E ULP-E began employment with the licensee June 21, 2011, to provide direct cares and services. On August 8, 2023, from 7:09 to 8:13 a.m., the surveyor observed ULP-E administer medication to five residents. ULP-E's employee record lacked documentation	0 650		

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0 650	Continued From page 9 for the following required annual training topics: - reporting maltreatment of vulnerable adults; - assisted living bill of rights; and - review of provider's policies and procedures. On August 7, 2023, at 2:39 p.m., CNS-C stated employees received annual training by EduCare (a training software) or during in-services in person. CNS-C stated the licensee had one training scheduled per month to cover the required content and verified their employee record documents provided to the surveyor lacked the content listed above. CNS-C stated they reviewed the annual training topics during their annual review, however, could not find documentation of this. On August 9, 2023, at 9:43 a.m., CNS-C stated they were unable to find the documentation for ULP-E's missing annual training content. On August 9, 2023, at 10:01 a.m., ULP-E stated they received annual training yearly based on the date of their hire. ULP-E was unable to recall all topics of training received. The licensee's Staff Orientation and Education dated August 1, 2021, indicated all staff providing assisted living services would complete at least eight hours of education for every 12 months of employment including the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 10 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a completed health history and symptom screening for two of three employees (unlicensed personnel (ULP)-A, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 660		

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0 660	Continued From page 11 found to be pervasive). The findings include: On August 7, 2023, at 10:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated employees should receive a health history screen and a TST, QuantiFERON gold, or chest x-ray upon hire to rule out TB. ULP-A ULP-A began employment with the licensee on March 13, 2023, to provide direct cares and services. ULP-A's employee record lacked a health history and symptom screening. On August 7, 2023, at 2:02 p.m., CNS-C stated they were unable to find ULP-A's health history and symptom screening. In addition, CNS-C stated they were on vacation when ULP-A was hired, and they did not know if ULP-A completed a health history screening upon hire. ULP-E ULP-E began employment with the licensee June 21, 2011, to provide direct cares and services. ULP-E's employee recorded included a health history and symptom screening and step-one TST completed on January 29, 2020, however lacked a second step TST. On August 9, 2023, at 9:00 a.m., housing manager (HM)-B stated they had no further testing information for ULP-E and they were unaware of why ULP-E did not receive a second step TST.	0 660		

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0 660	Continued From page 12 The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2021, indicated employees would receive a baseline TB screening upon hire which included an assessment for TB history and current TB symptoms. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 13 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license. 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: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review of the EPP; - quarterly review of missing resident policy; - a comprehensive all- hazard risk assessment; - EPP related to patient population; - process for emergency preparedness (EP) collaboration; - subsistence needs for staff and residents; - policies and procedures for sheltering in place;	0 680		

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0 680	Continued From page 14 - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - long term care family notifications; and - emergency prep testing to include a disaster drill. On August 8, 2023, at 12:10 p.m., housing manger (HM)-B stated the licensee conducted fire drills but have not conducted a disaster drill at the facility. In addition, HM-B stated the EPP was their responsibility, and they did not understand all the items that needed to be included in the EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan would be reviewed and updated at least annually. In addition, a disaster drill would be documented and conducted at the residence at least annually. No further 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 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 15 (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 in all sleeping rooms and failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 780		

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0 780	Continued From page 16 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 10, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Housing Manager (HM)-B and Executive Director (ED)-F. During the facility tour, it was observed that the sleeping rooms in resident units that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. During the interview, HM-B stated that this was consistent with all resident units throughout the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly	0 800		

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0 800	Continued From page 17 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 the potential to affect a large portion or all of the residents). The findings include: On August 10, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Housing Manager (HM)-B and Executive Director (ED)-F. During the facility tour, survey staff observed the following: Review of the available maintained record at approximately 1:00 p.m., it was observed that the automatic fire alarm system had not had an annual maintenance inspection. During the interview, HM-B made a phone call to the fire alarm system inspection company and confirmed that the fire alarm system annual inspection had not been performed since 8/13/2021. An annual maintenance inspection of the automatic fire alarm system is required. HM-B verified that the facility could not locate the annual inspection record and confirmed the deficiency. It was also observed that the fire sprinkler system did not have any indication that annual inspection and maintenance had been performed on the system. Maintenance records were requested to verify compliance but were not provided. Annual inspections of the fire sprinkler system are required to ensure that all systems are maintained and remain in working order.	0 800		

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0 800	Continued From page 18 In the kitchen on the ground floor, it was observed that the egress door from the kitchen to the stair did not close and self-latch. This door was identified as an exit by an overhead exit sign required to automatically close and latch to maintain the fire barrier of the space. In resident unit 7 on the first floor, it was observed that door closer in the resident door had been disabled by removing the closure arm or closure device. The door still had a portion or remnants of the closure device still mounted on the door. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. In resident unit 11 on the second floor, it was observed that excess material and equipment were stored in the unit. The room was filled with excess tools, computer equipment, a cigarette-making kit with tobacco mix, and household supplies. It was also observed that the carpet was damaged badly with thick stains, and the walls and ceiling were covered with dust. The unit was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program. 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	0 810		

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0 810	Continued From page 19 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct required evacuation drills twice per year per shift and every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 20 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: An interview and record review were conducted on August 10, 2023, at approximately 1:00 p.m. with the Housing Manager (HM)-B and Executive Director (ED)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Review of the provided documented drills indicated that the licensee had conducted fire drills on 4/6/23 at 12:25p.m. and 6/29/23 at 3:10 p.m. only. During the interview, HM-B verified that there were no further drills conducted besides those that were provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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.	01060		

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01060	Continued From page 21 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 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:	01060		

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01060	Continued From page 22 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) of the emergency relocation greater than four days, for one of one resident (R1) hospitalized. 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 admitted for assisted living services on July 27, 2022. R1's Progress notes dated May 27, 2023, through June 19, 2023, indicated R1 was transferred via ambulance to the hospital on May 29, 2023, for a change of condition after returning from an emergency room visit on May 27, 2023. R1 then transferred from the hospital to a transitional care unit and returned to the licensee on June 16, 2023, to resume assisted living services. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as	01060		

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01060	Continued From page 23 required. On August 8, 2023, at 11:15 a.m., CNS-C stated they were unaware of the emergency relocation notice requirement and if the licensee provided one, it would be something administration completed. Housing manager (HM)-B stated they were unaware if they provided an emergency relocation notice any of the residents who were relocated. On August 9, 2023, at 9:00 a.m., the surveyor received a template of the licensee's emergency relocation notice. HM-B inquired if the template would be acceptable to use. HM-B stated they do not have documentation of an emergency relocation notice going out to any resident, however, would use the template in the future. The licensee's Discharge and Transfer of Residents policy dated August 1, 2023, read, "In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to TotalCare Assisted Living Services within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01370	Continued From page 24	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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
01370	Continued From page 25 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel ((ULP)-A, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-A ULP-A began employment with the licensee on March 13, 2023, to provide direct cares and services. ULP-E ULP-E began employment with the licensee June 21, 2011, to provide direct cares and services. On August 8, 2023, from 7:09 a.m., to 8:13 a.m., the surveyor observed ULP-E administer medication to five residents. ULP-A and ULP-E's employee record lacked the following competency evaluations: - hair care and bathing;	01370		

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01370	Continued From page 26 - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. On August 9, 2023, at 9:19 a.m., clinical nurse supervisor (CNS)-C verified ULP-A and ULP-E's employee records lacked the content above. CNS-C stated they believed the licensee's skin care training coved the topics listed above. On August 9, 2023, at 9:42 a.m., CNS-C and housing manager (HM)-B reviewed the content of the skin course and stated it was not covered in the class and they would add the competencies to their orientation process and educate all ULP at the facility. The Staff Orientation and Education policy dated August 1, 2021, indicated those providing direct service would complete a competency evaluation as part of the orientation process and all clinical topics would be addressed by the registered nurse or other appropriately licensed health care professionals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and	01380		

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01380	Continued From page 27 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel ((ULP)-A, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-A ULP-A began employment with the licensee on March 13, 2023, to provide direct cares and services. ULP-E ULP-E began employment with the licensee June	01380		

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01380	Continued From page 28 21, 2011, to provide direct cares and services. On August 8, 2023, from 7:09 a.m., to 8:13 a.m., the surveyor observed ULP-E administer medication to five residents. ULP-A and ULP-E's employee record lacked the following competency evaluations: - range of motion and positioning. On August 9, 2023, at 9:19 a.m., clinical nurse supervisor (CNS)-C verified ULP-A and ULP-E's employee records lacked the content above. CNS-C stated they believed the licensee's mobility training coved the topics listed above, however after review, CNS-C stated the licensee did not complete the competency to all ULP. The Staff Orientation and Education policy dated August 1, 2021, indicated those providing direct service would complete a competency evaluation as part of the orientation process and all clinical topics would be addressed by the registered nurse or other appropriately licensed health care professionals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	01530		

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01530	Continued From page 29 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required amount of dementia care training in the required time frame for one of one employee (unlicensed personnel (ULP)-A). 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).	01530		

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01530	Continued From page 30 The findings included: ULP-A began employment with the licensee on March 13, 2023, to provide direct cares and services. At the time of the survey, ULP-A had worked 939 hours since date of hire. ULP-A's employee record included 6.25 hours of dementia training however, lacked documentation of the required eight (8) hours of dementia training within 160 hours of the employment start date. On August 7, 2023, at 2:32 p.m., clinical nurse supervisor (CNS)-C stated ULP should receive 8 hours of dementia care training when hired. In addition, direct staff needed to complete the dementia care training before they worked with residents and dementia training was also completed annually. On August 7, 2023, at 2:35 p.m., housing manager (HM)-B provided the surveyor with a EduCare (training software) list of what trainings were provided to the ULP. The list included 6.25 hour of dementia care training. On August 7, 2023, at 2:39 p.m., CNS-C stated, "it was our fault we only assigned the 6.25 hours. We thought it was eight hours. We will add it to EduCare and resent it out to everyone." The licensee's Dementia Education policy dated August 1, 2021, read, "Supervisors of direct-care staff will have at least eight (8) hours of initial education** within 120 working hours of employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (AOL's)	01530		

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01530	Continued From page 31 c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living 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	01640		

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01640	Continued From page 32 review, the licensee failed to ensure the service plan was revised to include all services being provided 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 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 admitted for assisted living services on July 27, 2022. R1's diagnoses included paranoid type schizophrenia (a mental disorder with symptoms of hallucinations, delusions, and disorganized thinking), diabetes, hypertension, hyperlipidemia (high cholesterol), and repeated falls. R1's Service Plan (Waiver)- Addendum to Contract signed March 14, 2023, indicated R1 received assistance with activities, appointment assistance, bathing reminders, CPAP, grooming reminders, housekeeping, laundry, behavior management, meals, medication administration, blood glucose monitoring five times per day, vital sign monitoring, safety checks, and shopping assistance. On August 8, 2023, at 12:43 p.m., the surveyor did not observe a continuous positive airway pressure (CPAP) machine in R1's room. R1's provider orders signed March 1, 2023,	01640		

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01640	Continued From page 33 indicated R1 received blood glucose monitoring four times per day. On August 10, 2023, via email correspondence at 7:38 a.m., CNS-C verified R1 did not use a CPAP machine and stated they would remove the CPAP service from R1's service plan right away. R1's service plan lacked a revision when the frequency of blood glucose was changed and when R1 no longer utilized a CPAP machine. In addition, R1's service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided when revisions occurred. On August 9, 2023, at 9:28 a.m., clinical nurse supervisor (CNS)-C stated when a service changed for a resident, they would update the service plan and have resident or guardian sign the new service plan. In addition, CNS-C stated the service plan for R1 should have been updated upon return from hospital in June of 2023 when the services changed, however, they did not know why they did not update the changes. The licensee's Service Plan policy dated August 1, 2021, indicated the licensee would provide all serviced required by the current service plan and the service plan must be revised if needed based on resident assessment. In addition, all service plan revisions were signed by a representative from the licensee and by the resident or resident's representative indicating an agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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01640	Continued From page 34 (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 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	01730		

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01730	Continued From page 35 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content 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 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 admitted for assisted living services on July 27, 2022. R1's diagnoses included paranoid type schizophrenia (a mental disorder with symptoms of hallucinations, delusions, and disorganized thinking), diabetes, hypertension, hyperlipidemia (high cholesterol), and repeated falls. R1's Service Plan (Waiver)- Addendum to Contract signed March 14, 2023, indicated R1 received assistance with activities, appointment assistance, bathing reminders, continuous	01730		

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01730	Continued From page 36 positive airway pressure (CPAP), grooming reminders, housekeeping, laundry, behavior management, meals, medication administration, blood glucose monitoring, vital sign monitoring, safety checks, and shopping assistance. R1's Med Admin Summary - Month dated August 1, 2023, through August 31, 2023, included nystatin 30 grams (g) apply one application to affected area twice per day, Refresh Dro Contacts instill one drop into affected eye three times daily, Aspercreme Lidocaine 4 percent (%) patch apply one patch daily as needed (PRN), diclofenac 1% gel apply 2 g topically to affected area four times daily PRN, Melatonin 1 mg take 1-2 tablets by mouth at bed time PRN if unable to sleep, and pain relief patch 4 % apply one patch PRN for pain keep on for 12 hours and remove for at least 12 hours. The orders listed above lacked specific resident instructions related to the medication administration. R1's ongoing assessment completed June 16, 2023, indicated resident preferred to take medication when they came downstairs and had a scheduled pain gel three times per day as ordered. R1's Service Plan (Waiver)-Addendum to Contract signed March 14, 2023, Med Admin Summary - Month dated August 1, 2023, through August 31, 2023, and ongoing assessment dated June 16, 2023, included parts of the individualized medication management record however, lacked specific resident instructions relating to the medication administration. On August 8, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-C stated specific resident instruction related to medication administration	01730		

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01730	Continued From page 37 should be listed on the medication administration record (MAR). The surveyor inquired where and how R1 received the medication listed above. CNS-C stated R1 received nystatin to the groin, pain gel and patches to the right knee, eye drop to both eyes, and for melatonin R1 should receive one tablet and if they are still unable to sleep, they can request the second tablet. CNS-C verified these instructions were not located on the MAR and stated they were unaware of why they were not located on the MAR. The licensee's Service Plan for Medication Management dated August 1, 2021, indicated a written medication management plan would include any resident specific requirements related to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

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01890	Continued From page 38 Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 7, 2023, at 10:47 a.m., the surveyor observed the medication closet and observed the following: - one NovoLog FlexPen opened without a legible date open label for R1; and - one Lantus SoloStar pen without a date open label for R1. On August 7, 2023, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to mark times sensitive medication with the date opened by use of a sharpie pen. In addition, CNS-C stated they believed the ULP marked the medications listed above with the date opened however, the sharpie marker rubbed off the insulin pens. The manufacturer's instructions for Lantus SoloStar pen dated 2022 recommended Lantus SoloStar pen be discarded 28 days after opening. The manufactures instructions for NovoLog FlexPen dated January 2019 recommended	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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	Continued From page 39 NovoLog FlexPen be discarded 28 days after opening. The licensee's Storage/ Control of Medications policy dated August 1, 2021, indicated the licensed nurse was responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *08/07/23*
Time: 11:13:10
Report: 7994231153

Food and Beverage Establishment Inspection Report

Location:

Totalcare Assisted Livining Se
2730 Winnetka Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0038085
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632051702
ID #:

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

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

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

HANDWASH SINK SENSOR IS BROKEN AND A WORK ORDER HAS ALREADY BEEN PLACED FOR IT TO BE REPAIRED. RINSE SINK IS BEING USED AS A TEMPORARY HANDWASH SINK.

Comply By: 08/07/23

4-200 Equipment Design and Construction

4-201.11GMN

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

CURRENTLY FACILITY IS SAVING SOME FOODS FROM ONE DAY TO ANOTHER. SPOKE WITH MANAGER ABOUT THE OPTIONS FOR COMPLYING WITH THE ABOVE REQUIREMENTS.

Comply By: 08/14/23

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

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
MILK 40
SLICED MEATS 40

Food and Beverage Establishment Inspection Report

FRUIT 39

OLD CFPM LEFT THE FACILITY ABOUT A WEEK AGO AND NEW MANAGER JUST TOOK CERTIFICATION TEST

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 7994231153 of 08/07/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
Establishment Representative

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

Report #: 7994231153

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1	**Date**	08/07/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:13:10
Legal Authority MN Rules Chapter 4626		**Time Out**	

Totalcare Assisted Livining Se	**Address** 2730 Winnetka Avenue North	**City/State** New Hope, MN	**Zip Code** 55428	**Telephone** 7632051702
License/Permit # 0038085	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/07/23

Inspector (Signature) Crystal Elva