Electronically Delivered

August 1, 2024

Licensee
Merry Lake LLC
14803 Belvoir Drive
Minnetonka, MN 55345

RE: Project Number(s) SL36981015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 5, 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.

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. 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 - 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 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

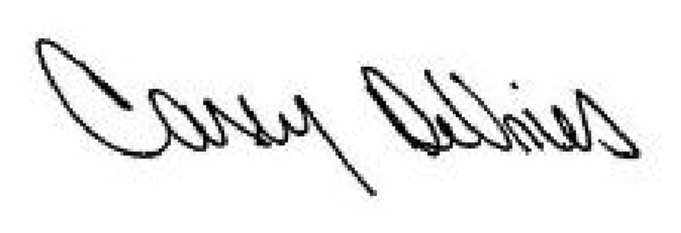
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36981	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

(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: SL36981015-0 On July 1, 2024, through July 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four indivduals residing in the facility, all four residents were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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

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0 470	Continued From page 2 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 July 1, 2024, at 11:00 a.m., during a tour of the facility the surveyor observed an undated schedule that indicated the licensed assisted living director's (LALD) scheduled work time at the facility was on Fridays at 9:00 a.m. The schedule did not include the duration of LALD's planned shifts on Fridays and did not include the schedule for any other staff members. The surveyor did not observe a schedule for unlicensed personnel. On July 1, 2024, at 11:30 a.m., via telephone, LALD-D stated a daily staffing schedule would be posted on the bulletin board by the computer desk in the facility. LALD-D was out of town from June 20, 2024, and planned to return on July 9, 2024. On July 1, 2024, at 12:43 p.m., the surveyor observed a form behind the LALD schedule titled Staffing Schedule. The staffing schedule document was not completed. House manager (HM)-C stated the facility did not have a posted schedule. HM-C stated everyone knew when they were working, and residents knew who was working. Unlicensed personnel (ULP)-B was also present and stated the facility did not have a posted staffing schedule. On July 5, 2024, via telephone interview LALD- D stated the facility's twenty-four-hour staffing schedule should be posted every two weeks. LALD-D stated in his absence it had been	0 470		

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0 470	Continued From page 3 assigned to ULP-B to update and post the schedule. The licensee's Staffing policy dated August 1, 2021, indicated the facility daily staffing schedule would be prepared by the clinical nurse supervisor and posted in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 480		

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0 480	Continued From page 4 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 2, 2024 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 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 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 to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors.	0 510		

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0 510	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B ULP-B had a hire date of February 20, 2021. ULP-B provided direct services to residents. ULP-B's employee record indicated completion of a handwashing procedure skills competency, dated March 29, 2021. On July 1, 2024, during continuous observation from 3:02 p.m. to 3:23 p.m., the surveyor observed ULP-B apply gloves without performing hand hygiene. With the gloves on, ULP-B prepared medications for R2, brought the medications to R2 in R2's bedroom on main level of facility, then returned to the front living room of the facility, and documented administration of R2's medications. Without performing hand hygiene, ULP-B accessed the medication cabinet, prepared medications for R4, walked downstairs to R4's bedroom, then back upstairs and outside to find R4, and administered R4's medications. With the same gloves still on, ULP-B went back to the front living room and documented administration of R4's medications on the desktop computer used by facility staff. At 3:23 p.m., ULP-B left the front living room and returned with gloves off. The surveyor did not observe ULP-B complete hand hygiene or	0 510		

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0 510	Continued From page 6 change gloves at any time during continuous observation. On July 1, 2024, at 3:27 p.m., ULP-B stated they were trained on handwashing by the registered nurse. ULP-B stated they were trained to wash their hands at start of their work shift, after any service for a resident, after removal of gloves, and after any task is completed. ULP-B stated they usually wash their hands and change gloves during the medication pass. On July 5, 2024, at 9:00 a.m., via telephone interview clinical nurse supervisor (CNS)-A stated employees received training for handwashing that included washing hands with soap and running water for twenty to thirty seconds, drying their hands with a paper towel, and using the paper towel to shut off the running water faucet. CNS-A stated employees were expected to wash their hands at the start of their shift, before and after care is provided to a resident, before working in the kitchen, after using the restroom, before donning gloves, after removing gloves, and before and after medication administration. CNS-A stated employees should wear gloves when preparing and administering medications and should change gloves and perform hand hygiene between residents during a medication pass. The licensee's Infection Control policy dated August 1, 2021, indicated employees would wash their hands when contaminated with blood or body fluids, immediately after gloves are removed, between resident contacts, and when indicated. In addition, the policy specified hands should be washed after changing beds, before assisting with medications, before and after treatments, after all pet care, after housekeeping,	0 510		

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0 510	Continued From page 7 after emptying bed pans, after assisting residents to the toilet, after removing items from the floor, before preparing food, before feeding residents, after using the bathroom, after coughing or sneezing, after smoking, after handling plants, and after removing gloves. The Center of Disease Control (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, recommended hand hygiene to be performed immediately before touching a patient (resident), before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient (resident), after touching a patient or the patient's (resident's) immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities	0 550		

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0 550	Continued From page 8 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 post required information related to their grievance procedure and the Office of Health Facility Complaints (OHFC) contact information at the Minnesota Department of Health (MDH). 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 July 1, 2024, at 12:43 p.m., the surveyor observed the licensee's undated Grievance Policy and Procedure document posted in the front living room by the staff computer desk. The posting included the name and telephone number for the individual responsible for handling resident grievances, however lacked email contact information for that individual. The posting lacked the statement 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	0 550		

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0 550	Continued From page 9 Health. The posting did not include the contact information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On July 5, 2024, at 10:10 a.m., licensed assisted living director (LALD)-D stated via telephone interview they thought the posting included all information needed. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure would be conspicuously posted in the residence including the following information: - name, phone number and email contact information for the individuals who are responsible for handling resident complaints; - contact information for the state and any regional Office of Ombudsman for Long-Term-Care; - contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 10 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of three employees (house manager (HM)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB Risk Assessment last completed on October 31, 2023, indicated the facility's risk level to be low. HM-C had a hire date of March 3, 2020. HM-C provided direct services to residents.	0 660		

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MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

(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
0 660	Continued From page 11 HM-C's employee record included a test results letter from a health care clinic, dated January 7, 2021, that included results for a TB QuantiFERON gold plus blood test indicating a positive reaction for TB. The letter lacked information on a current plan. HM-C's employee record included chest x-ray study results dated December 18, 2000, that indicated no evidence of active tuberculosis. HM-C's record lacked chest x-ray results indicating no evidence of active TB taken after the positive TB test from January 7, 2021. On July 5, 2024, via telephone interview licensed assisted living director (LALD)-D stated they completed a facility TB risk assessment annually. LALD-D stated new employees should have a TB assessment and skin test, blood test, or chest x-ray completed before working with residents. The licensee's Tuberculosis Screening/ Prevention policy dated August 1, 2021, indicated the director was responsible for conducting a formal TB risk assessment and updating it annually. In addition, employees with a documented history of a positive TB test must also have documented history of a chest x-ray performed after the date of the position TB test indicating no active TB disease. Regulations for Tuberculosis Control in Minnesota Health Care Settings: A guide for implementing tuberculosis infection control regulations in your facility, dated July, 2013, indicated before the health care worker (HCW) has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms,	0 660		

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0 660	Continued From page 12 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and 4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 13 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on 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 receiving services 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: On July 1, 2024, at 11:30 a.m., via telephone licensed assisted living director (LALD)-D stated all documents related to the emergency preparedness plan were contained in a binder at the facility.	0 680		

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0 680	Continued From page 14 On July 1, 2024, at 12:00 p.m., house manager (HM)-C provided the surveyor with a binder that contained the licensee's EPP. The EPP dated August 1, 2021, lacked the following required content: - quarterly review of the missing resident policy; - a process for collaboration with local, tribal, regional, state and federal emergency preparedness officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking location of on-duty staff and sheltered residents; - procedures for medical documents; and - the use of volunteers; - roles under a waiver declared by Secretary; - names and contact information for staff, entities providing services under agreement, residents' physicians; other facilities, and volunteers; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; and - means to release resident information and provide general condition/ location of residents under facility's care. On July 5, 2024, at 10:10 a.m., via telephone interview LALD- D stated the missing resident policy was reviewed annually with all facility policies. LALD-D stated they believed all emergency preparedness components were at the facility but would review and update upon returning from time off. LALD-D had been out of the office since June 20, 2024, and planned to return on Tuesday, July 9, 2024.	0 680		

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0 680	Continued From page 15 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subpart 4 Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of written and electronic records for four of four residents.	0 700		

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0 700	Continued From page 16 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: WRITTEN RECORDS On July 1, 2024, at 11:00 a.m., during the facility tour, the surveyor observed a white dry-erase board calendar on the wall of the front living room. The calendar included resident protected information which included R2's initials or name along with their medical appointments and sticky notes posted on the calendar with additional information specifying appointments for psychiatry, injections, and magnetic resonance imaging (MRI). ELECTRONIC RECORDS On July 1, 2024, at 1:02 p.m., the surveyor observed RTasks (electronic medical record) open on the desktop computer in the living room. The living room was open to the dining room, hallway to bedrooms, the main entrance to the facility, and the stairway to lower level. The desk was up against the wall with the computer screen facing the room. All residents, staff, and visitors would pass through living room to move from the lower level or main entrance to the rest of the house. R4 and R5 who resided on the lower level frequently passed through the living room to go from their rooms to the kitchen or outside to the backyard. The surveyor observed RTasks to display daily tasks for unlicensed personnel to record completion for July 1, 2024. The tasks	0 700		

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0 700	Continued From page 17 included full names of all four residents, details of socialization, and safety check activities for each individual resident. ULP-B returned to the computer at 1:04 p.m., and after less than one minute left the desk with RTasks screen still up and went downstairs, returned to the desk at 1:05 p.m., then left the desk with RTasks still open and visible at 1:09 p.m. The computer remained unattended with the screen up until 1:57 p.m. On July 5, 2024, via telephone interview licensed assisted living director (LALD)- D stated ULPs were expected to keep resident information confidential. LALD-D stated everyone had their own password and should log on when they begin documenting and log off when they walk away from the computer. On July 5, 2024, via telephone interview clinical nurse supervisor (CNS)-A stated ULPs could use their cell phone, facility tablets, or the facility computer to document their work. CNS-A stated when ULPs used the computer to document they should be alone in the room and lock the computer screen when they walk away. The licensee's Privacy of Protected Health Information policy dated August 1, 2021, indicated the licensee would protect the privacy of resident's personal health information and no personal health information about residents would be accessible in public areas of the facility and information stored in computers would remain password protected. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 720	Continued From page 18	0 720		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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 July 1, 2024, at 9:20 a.m., the surveyor called the licensee and spoke with house manager (HM)-C to announce survey entrance planned for 10:00 a.m. HM-C requested to reschedule the survey to another week due to licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-A, and owner (O)-E all being out of town for the week. The surveyor advised the survey	0 720		

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0 720	Continued From page 19 would begin at 10:00 a.m. On July 1, 2024, at 12:00 p.m., HM-C stated they had received the entrance email sent to the facility email address. HM-C stated the facility email address would be the best email for the surveyor to use for documentation requests. On July 1, 2024, at 1:57 p.m., the surveyor observed an employee list in the survey binder dated June 15, 2024. The surveyor asked HM-C if the list was still accurate. HM-C stated they were not sure if the list was still accurate. The surveyor asked for an updated employee list and schedule for the week. HM-C stated with everyone on vacation they did not have that information. HM-C stated they and unlicensed personnel (ULP)-B were working all week and figured out the schedule between them. The schedule for the week was not provided during survey. An updated employee list was not provided. On July 1, 2024, at 1:57 p.m., the surveyor made a verbal request to review employee records of ULP-B and CNS-A. The paper records were provided for review. The surveyor asked for Educare (electronic learning management system) transcripts to review orientation and annual education. HM-C stated O-E was the individual that had access to Educare and they did not think they would not be able to provide those records since O-E was out of town. On July 1, 2024, at 2:49 p.m., the surveyor requested an update on the Educare transcripts. HM-C stated they had been attempting to reach O-E for log in access and password information but could not reach them and without access to the Educare program there was nothing they	0 720		

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0 720	Continued From page 20 could do. ULP-B went online and printed their own Educare transcript for 2024 but did not have access to previous years. HM-C stated they thought the lack of access to previous years had something to do with the previous LALD. On July 1, 2024, at 3:56 p.m., the surveyor sent an email request to the facility email address for resident record information they planned to review on July 2, 2024. On July 2, 2024, at 3:46 p.m., the surveyor sent an email request to the facility email address for documents that had been requested previously but not yet provided. On July 2, 2024, at 4:31 p.m., the surveyor resent the email to the facility email address at the request of HM-C who stated the previous message was no longer in the email box. On July 3, 2024, at 4:30 p.m., the surveyor sent an email to the facility email address requesting documents that had not yet received and additional information. The surveyor advised HM-C the email had been sent and requested the items be printed. HM-C and ULP-B stated they did not have access or know how to print anything from RTasks. The surveyor asked how the forms had been printed Monday evening for review Tuesday morning. HM-C stated the request was emailed to CNS-A who was on vacation in Wisconsin. CNS-A printed and faxed the documents back to the facility for to be printed for the surveyor. HM-C stated CNS-A would not be able to do that again but could email the documents when they returned from vacation on July 6, 2024. On Friday, July 5, 2024, at 11:59 a.m., an email	0 720		

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0 720	Continued From page 21 was sent to the facility email address indicated the survey was concluded. On Tuesday, July 9, 2024, after the survey had concluded, CNS-A emailed some of the documents that had been requested during the survey to the surveyor. CNS-A sent the emails to the surveyor at 10:11 a.m., 10:13 a.m., and 10:57 a.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 720		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 22 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-C. During the tour, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing and actuation of one alarm would not cause all alarms to operate. During the interview on July 2, 2024, at 1:30 p.m., HM- verified that not all smoke alarms in the facility were interconnected and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 23 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 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 July 2, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed the following items:	0 800		

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0 800	Continued From page 24 In the basement living room, it was observed that there were considerable brown stains on the gypsum sum ceiling with evidence of water damage. Outside of the main entrance door, it was observed that there was a large hole in the exterior soffit, and the soffit was damaged. During the interview on July 2, 2024, at 1:30 p.m., HM-C visually verified these deficient findings at the time of discovery. . TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety and building requirements. 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	0 830		

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0 830	Continued From page 25 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, at 1:00 p.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed the following items: It was observed that the facility was under ongoing construction which consists of window replacements. During the tour, it was observed that windows were replaced, but the installation was incomplete. The exterior plywood at the perimeter of a new window was exposed without any weather barrier, and exterior sidings were not installed to protect the building. During the phone interview on July 2, 2024, at 1:30 p.m. with the licensed assisted living director (LALD)-D, the survey staff asked LALD-D if the construction work was done with MDH review and prior approval or with an approved construction permit from the local Building Official. LALD-D stated the building owner did the construction work and that he thought the owner had received the construction permit. LALD-D stated he would request the permit from the owner, which would be provided via email as a follow-up. However, no follow-up email has been received from the facility. During the same interview, survey staff explained to LALD-D that renovation or physical changes altering the use of occupancy of a licensed assisted living facility must be submitted to MDH Engineering for review and approval. LALD-D stated he was not aware of the Minnesota Department of Health approval requirement and	0 830		

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	36981	A. BUILDING: _____ B. WING _____	07/05/2024

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0 830	Continued From page 26 verified this deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of four residents (R2 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On July 1, 2024, at 12:00 p.m., house manager (HM)-C presented the surveyor with a blank copy of the assisted living contract used by the facility. The blank contract included a thirteen page assisted living contract document. Page thirteen of the contract document included signature authentication for the resident or representative, facility staff member, and the date. In addition to the contract documents there were nine documents labeled as exhibits one through nine. HM-C stated the exhibit documents and the contract were completed at the time of move in for a new resident. The exhibit documents included: - exhibit one: Designation of Representative - exhibit two: Service Plan - exhibit three: Schedule of Fees - exhibit four: Minnesota Medical Assistance Program - exhibit five: Designation of Financial	0 900		

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0 900	Continued From page 28 Representative - exhibit six: Resident Managed Risks - exhibit seven: Agreement To Guarantee This Contract - exhibit eight: Lead Based Paint Disclosure - exhibit nine: Move In Checklist R2 R2 was admitted to the licensee and began receiving assisted living services on January 15, 2024. R2's diagnoses included chronic pain, obesity, bipolar disorder, and schizoaffective disorder. R2's Service Plan- Addendum to Contract, dated January 15, 2024, indicated R2 received medication administration, assistance with dressing, grooming, housekeeping, laundry, behavior management, safety checks, and socialization. R2's record contained completed contract exhibits three, four, five, six, seven, eight, and nine all signed on January 15, 2024, however, lacked a current assisted living contract. R5 R5 was admitted to the licensee and began receiving assisted living services on July 5, 2022. R5's diagnoses included fibromyalgia. R5's record lacked a current signed service plan. R5's record contained completed contract exhibits three, four, six, seven, eight, and nine signed on July 7, 2022, however, lacked a current assisted living contract.	0 900		

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0 900	Continued From page 29 On July 2, 2024, at 1:02 p.m., via telephone licensed assisted living director (LALD)-D stated they remembered completing R2's admission and reviewing the contract. LALD-D stated the contract may have been misfiled. On July 3, 2024, at 12:00 p.m., house manager (HM)-C stated they had looked through file cabinet papers, other binders, and medical records and were not able to locate a signed contract for R2. HM-C had R2 sign a new assisted living contract on July 2, 2024. On July 5, 2024, at 10:10 a.m., LALD-D stated they did not know if R5 had a signed contract as R5 moved into the facility prior to LALD-D starting employment with the facility. LALD-D stated R5 could be very challenging as R5 did not want to sign documents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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	01060		

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01060	Continued From page 30 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: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R2).	01060		

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01060	Continued From page 31 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: R2 was admitted to the licensee and began receiving assisted living services on January 15, 2024. R2's diagnoses included bipolar disorder, schizoaffective disorder, diabetes, chronic pain, and obesity. R2's Service Plan- Addendum to Contract, dated January 15, 2024, indicated R2 received medication administration, assistance with dressing, grooming, housekeeping, laundry, behavior management, safety checks, and socialization. R2's record included an Inter-Agency Transfer Form, dated April 19, 2024, which indicated R2 was inpatient at a hospital beginning on April 5, 2024, and was discharged from the hospital on April 19, 2024. R2's Clinical Update Assessment, dated April 20, 2024, indicated R2 returned to licensee on April 19, 2024, at 6:00 p.m., following an inpatient hospitalization. R2's record lacked a written notice delivered to the resident or designated representative that	01060		

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01060	Continued From page 32 contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - 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 - 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. In addition, R2's record lacked notification to OOLTC when R2 did not return to the facility within four days. On July 2, 2024, at 5:00 p.m., the Regional Ombudsman for Long-Term Care indicated via email that no emergency relocation forms were received by them from the licensee. On July 5, 2024, via telephone interview clinical nurse supervisor (CNS)-A stated they had not completed an emergency relocation form for R2 when they were hospitalized in April 2024. CNS-A stated the Office of the Ombudsman for Long-Term Care had not been notified of R2's hospitalization that extended beyond four days inpatient. CNS-A stated they were not aware of the requirements for emergency relocation and ombudsman notification and had not completed either for any hospitalization of facility residents. No further information was provided.	01060		

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01060	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (house manager (HM)-C).	01440		

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01440	Continued From page 34 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: HM-C had a hire date of March 3, 2020. HM-C provided direct services to residents. On July 2, 2024, at 2:59 p.m., the surveyor observed HM-C prepare and administer medications for R2 and R4. HM-C's record did not contain any documentation of supervision, therefore lacked evidence a RN conducted direct supervision of HM-C within 30 days of performing delegated tasks, as required. On July 5, 2024, via telephone interview clinical nurse supervisor (CNS)-A stated they perform direct supervision of new employees at thirty days of working in the facility. CNS-A stated they did not know the process previous CNS had or documented but agreed that each employee should have documentation of thirty-day direct supervision from the registered nurse. CNS-A was hired December 1, 2023. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated the registered nurse would provide direct supervision of employees performing delegated tasks within thirty days after the individual began working for the assisted living facility. In addition,	01440		

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01440	Continued From page 35 documentation of the supervision would be retained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 36 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of two employees (clinical nurse supervisor (CNS)-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	01470		

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01470	Continued From page 37 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-A began employment with the licensee on December 1, 2023, to provide oversite to unlicensed personnel and direct services to residents. CNS-A's employee record lacked the following required orientation content: - an overview of assisted living statutes; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - handling of residents' complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On July 1, 2024, at 10:30 a.m., CNS-A stated they were responsible for providing education to new employees. On July 1, 2024, at 4:00 p.m., the surveyor observed CNS-A's employee record contained orientation to facility policies and a dementia training tracking form that included training related to person centered planning but lacked any other orientation documentation including the Orientation Checklist referenced in licensee's	01470		

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01470	Continued From page 38 Staff Orientation and Education policy. On July 5, 2024, at 9:00 a.m., via telephone interview CNS-A stated they had not completed any online learning modules as part of their orientation. CNS-A stated they completed orientation independently by reading the facility policy and procedure manual, reviewing education binder, and took some tests. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated before providing services to residents, all employees would attend general orientation that included the following topics: - overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; - policies and procedures related to the provision of assisted living services; - handling of emergencies and the use of emergency services; - identification and reporting of maltreatment; - the Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; - principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; - consumer advocacy services; - the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure; and - the organizational chart and roles of staff within the facility. In addition, the Orientation Checklist would be completed and retained to verify the completion of orientation for each employee. No further information was provided.	01470		

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01470	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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	36981	A. BUILDING: _____ B. WING _____	07/05/2024

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MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

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01500	Continued From page 40 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees that performed direct services completed all required training components for each twelve months of employment for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01500		

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01500	Continued From page 41 situation has occurred only occasionally). The findings include: ULP-B had a hire date of February 20, 2021. ULP-B provided direct services to residents. On July 1, 2024, at 3:02 p.m., the surveyor observed ULP-B prepare and administer medications for R2 and R4. ULP-B's employee record lacked training for the following required topics: - review of provider policies and procedures for 2022 and 2024. On July 5, 2024, at 10:10 a.m., via telephone interview licensed assisted living director (LALD)-D stated annual education was completed around the employee's hire date but planned to have everyone complete annual education in January beginning next year. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all employees would receive at least eight hours of education for every twelve months of employment. Annual education would include: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - infection control techniques used in the home; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 42 Disease or related disorders; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. In addition, the policy indicated licensee would maintain proof of orientation and education in personnel files. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530		

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01530	Continued From page 43 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training for two of three direct care employees (clinical nurse supervisor (CNS)-A and house manager (HM)-C). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for one of two direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A was hired on December 1, 2023, to provide direct services to residents. CNS-A's employee record included 4 hours of dementia training on December 1, 2023, however lacked the required full eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents. On July 5, 2024, at 9:00 a.m., via telephone interview CNS-A stated they spent four hours total on orientation at the facility. CNS-A stated they	01530		

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01530	Continued From page 44 had worked approximately 190 hours since they were hired. HM-C HM-C was hired on March 3, 2020, to provide direct services to residents. HM-C's employee record included one hour of dementia training on March 30, 2021, however lacked the required full eight hours of initial training within one-hundred sixty hours of the start date for providing direct care to assisted living residents. ULP-B ULP-B was hired on February 20, 2021, to provide direct services to residents. ULP-B's employee record lacked the required two hours of annual dementia training for 2022 and 2024. On July 5, 2024, at 10:10 a.m., via telephone interview licensed assisted living director (LALD)-D stated annual dementia education was completed around the employee's hire date but would move to January for everyone beginning in 2025. LALD-D stated employees should have received eight hours of in person or Educare (computer-based learning management system) training on dementia related topics when hired and two hours annually. The licensee's Dementia Education policy August 1, 2022, indicated all employees would be knowledgeable in how to provide safe, effective services related to dementia. Supervisors of direct care employees would have at least eight hours of initial dementia education within one-hundred twenty working hours or employment, direct care employees would complete at least eight hours of initial dementia	01530		

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01530	Continued From page 45 education within one-hundred sixty hours of their employment start date, and all employees would have at least two hours of education on topics related to dementia for each twelve months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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.	01620		

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01620	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within fourteen days of the initiation of services and every 90 days thereafter for three of four residents (R2, R3, and 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: R2 R2 was admitted to the licensee and began receiving assisted living services on January 15, 2024. R2's Service Plan- Addendum to Contract, dated January 15, 2024, indicated R2 received medication administration, assistance with dressing, grooming, housekeeping, laundry, behavior management, safety checks, and socialization. R2's record indicated the RN completed an admission assessment on January 15, 2024. The RN completed a reassessment on January 29, 2024, fifteen days after the admission assessment. R3	01620		

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01620	Continued From page 47 R3 was admitted to the licensee and began receiving assisted living services on December 18, 2022. R3's diagnoses included epilepsy and depression. R3's Service Plan- Addendum to Contract, dated December 10, 2023, indicated R3 received medication administration dressing, grooming, bathing, housekeeping, laundry, behavior management, safety checks, and socialization. R3's record indicated the RN completed an admission assessment on December 8, 2022. The RN completed an initial reassessment on December 23, 2022, fifteen days after the admission assessment. R3's record indicated the RN completed an assessment on February 28, 2024. The next assessment completed by the RN occurred on June 11, 2024, one-hundred four days after the previous assessment. R4 R4 was admitted to the licensee and began receiving assisted living services on October 13, 2021. R4's diagnoses included major depressive disorder. R4's record indicated the RN completed an assessment on February 26, 2024. The next assessment completed by the RN occurred on June 11, 2024, one-hundred six days after the previous assessment. On July 1, 2024, at 10:30 a.m., via telephone	01620		

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01620	Continued From page 48 interview clinical nurse supervisor (CNS)-A stated they were responsible for completing all resident assessments. CNS-A stated they completed the admission assessment the day a resident moved in, completed a reassessment within the next fourteen days, ongoing assessments every ninety days, and an additional assessment if a resident had a change in condition. On July 5, 2024, at 9:00 a.m., via telephone interview CNS-A stated they kept track of when assessments were due on their cell phone calendar and did not recall why the assessments were not completed on time. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the registered nurse would complete an initial assessment for each resident on or before the date the resident moves into the facility, reassessment would occur no more than fourteen days after initiation of services, and ongoing reassessments would not exceed ninety days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written	01690		

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01690	Continued From page 49 medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and implement measures to ensure security and accountability for the overall management, control, and disposition of controlled substances in compliance with state and federal regulations. 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	01690		

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01690	Continued From page 50 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: R2 was admitted to the licensee and began receiving assisted living services on January 15, 2024. R2's diagnoses included chronic pain, obesity, bipolar disorder, and schizoaffective disorder. R2's Service Plan- Addendum to Contract, dated January 15, 2024, indicated R2 received medication administration. R2's Medication Administration Summary for July 2024 indicated R2 had oxycodone 5 milligram (mg)/ acetaminophen (apap) 325 mg combination tablets and could take one tablet up to three times daily as needed for severe pain. On July 3, 2024, at 12:50 p.m., the surveyor observed R2 request one oxycode/apap tablet for "bad" knee pain. House manager (HM)-C removed medication cabinet keys from an unlocked drawer in the front living room computer desk, then unlock the medication cabinet, removed a locked box from the medication cabinet, unlocked the box, removed three cards of oxycodone/ apap from the box. Then HM-C made a phone call and was speaking to someone via Bluetooth ear device while counting and preparing medication. The surveyor asked if HM-C was talking with the nurse and HM-C replied "no". The surveyor asked who HM-C was talking with during the medication pass and HM-C	01690		

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01690	Continued From page 51 replied, "other staff". HM-C was speaking a language not understood by the surveyor into the phone. HM-C counted all three cards of oxycodone/ apap, punched out one pill into a medication cup, then returned the medication cards to the locked box, the locked box to the medication cabinet, locked the medication cabinet, and placed the key in the unlocked desk drawer. HM-C brought the medication to R2 in R2's bedroom, returned to the front room, and documented on their cell phone. The surveyor asked to view the controlled substance record. HM-C stated they did not have a written record of the count. HM-C stated the staff count how many tablets there are and call the person that worked before them to ask how many there should be. HM-C stated they had called unlicensed personnel (ULP)-B during the medication pass to ask what the count was on his shift. On July 5, 2024, at 9:00 a.m., via telephone interview clinical nurse supervisor (CNS)-A stated they expected employees to perform a count of controlled substances at the change of each shift and when a controlled substance is administered to a resident. CNS-A stated they had tried to work with the facility's electronic medical record technical support to set up the capability for documentation of controlled substance counting in the electronic medical record. CNS-A had initiated a paper document for employees to document the count of controlled substances but there were issues with employees not completing the paper documentation or handwriting was not legible. CNS-A stated they were aware employees were doing a verbal count and communicating between each other. CNS-A stated the verbal counting method did not meet	01690		

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01690	Continued From page 52 the requirements of facility policy. CNS-A stated that no written protocol or procedure had been developed to monitor and maintain security of controlled medications. The licensee's Storage/ Control of Medications policy dated August 1, 2021, indicated the registered nurse was responsible for establishing the protocol for monitoring and securing controlled medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all prescription medications remained in securely locked compartments with only authorized personnel having access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01880		

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01880	Continued From page 53 or has the potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, at 12:56 p.m., the surveyor observed house manager (HM)-C remove keys from an unlocked drawer of computer desk in the front living room, unlock the medication cabinet, remove medical record requested by surveyor, lock the cabinet, and place the keys back into the unlocked drawer of the computer desk. The front living room was an open space that connects with dining area, kitchen, front door, stairway to lower level, and hallway to main level bedrooms. Entrance to these areas was open without doors present, and all residents were independent with ambulation, R3, R4, and R5 moved throughout the house with no adaptive equipment or physical limitations. R2 had impaired mobility and used a walker but could access all areas of the facility main level. On July 2, 2024, at 1:08 p.m., HM-C left the front living room and toured entire house with Minnesota Department of Health (MDH) Environmental Engineer. The keys remained in the unlocked drawer. R3, R4, and R5 wandered throughout the main level of the facility during this time and were in the front living room unattended. At 2:36 p.m., HM-C and the MDH Environmental Engineer completed the tour and HM-C returned to the front living room. The keys remained in the drawer. On July 2, 2024, at 2:59 p.m., the surveyor observed HM-C remove the keys from the unlocked drawer and complete a medication pass for two residents. At 3:10 p.m., HM-C placed the keys back in the unlocked drawer of the computer	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36981	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

(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
01880	Continued From page 54 desk in the front living room. On July 3, 2024, at 11:45 a.m., the surveyor observed HM-C go to the lower level of the facility for housekeeping. HM-C returned to the main level at 12:23 p.m. During this time R4 walked through front living room on way from R4's lower-level bedroom to outside via house back door by the kitchen three times. At 12:50 p.m., the surveyor observed HM-C remove keys from unlocked drawer of computer desk in front living room, unlock the medication cabinet, prepare medications for R2, lock the cabinet, place the keys back into the unlocked drawer of the computer desk, and HM-C left the room. At 1:05 p.m., HM-C returned to the front living room but left the keys in the drawer. R2's Individualized Medication Management Plan dated April 20, 2024, indicated all medications are secure and locked away in a locked medication cabinet. On July 5, 2024, via telephone interview licensed assisted living director (LALD)-D stated employees responsible for medications should always keep the medication cabinet key on their person. LALD-D stated the key was on a lanyard and employees could wear it around their neck or keep it in a pocket. LALD-D stated the unattended desk was not a secure location for the medication cabinet key. On July 5, 2024, via telephone interview clinical nurse supervisor (CNS)-A stated their expectation of employees passing medications would be for them to keep the key secure on their person. CNS-A stated it was not okay for employees to keep the medication cabinet key in the drawer by the computer.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36981	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

(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
01880	Continued From page 55 The licensee's Storage/ Control of Medications policy dated August 1, 2021, indicated all prescription medications are securely locked and only authorized staff would have access to them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of three 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 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:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36981	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

(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 56 On July 1, 2024, at 3:15 p.m., during review of the medication storage area with house manager (HM)-C, the surveyor observed empty product boxes for the following medications for R3. The empty boxes were without an opened-on date. - budesonide and formoterol fumarate dihydrate inhalation aerosol; and - Ventolin hydrofluoroalkane (HFA) inhalation aerosol. On July 2, 2024, at 4:22 p.m., the surveyor requested R3 show them the inhalers they kept with them for self-administration. R3 brought the inhalers to the dining room. The surveyor observed R3's budesonide and formoterol fumarate dihydrate inhalation aerosol and R3's Ventolin HFA inhalation aerosol. Neither inhaler had an opened-on date written on them. Manufacturer instructions for budesonide and formoterol fumarate dihydrate inhalation aerosol, revised on July 24, 2019, indicated the inhaler should be discarded when the labeled number of inhalations have been used or within 3 months after removal from the foil pouch. Manufacturer instructions for Ventolin HFA inhalation aerosol, revised May 6, 2024, indicated the inhaler should be discarded when the counter reads 000 or the expiration date printed on the box has been reached. On July 5, 2024, via telephone interview clinical nurse supervisor (CNS)-A stated open medications should have the date they were opened written on the medication container. The licensee's Storage/ Control of Medications policy dated August 1, 2021, indicated the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36981	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY LAKE LLC	14803 BELVOIR DRIVE MINNETONKA, MN 55345

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01890	Continued From page 57 licensed nurse is 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
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/02/24*
Time: 11:00:00
Report: 8041241122

Food and Beverage Establishment Inspection Report

Location:
Merry Lake Llc
14803 Belvoir Drive
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0037999
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636003920
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

TCS FOODS IN THE GE REFRIGERATOR MEASURED ABOVE 41F. REFRIGERATOR HAD AN AMBIENT AIR TEMP. OF 43F. SEE TEMP. LOG AND COMMENTS. TEMPERATURE DIAL WAS ADJUSTED DURING INSPECTION. ADJUST/REPAIR AS NEEDED.

Comply By: 07/02/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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

SMALL DIAMETER PROBE THERMOMETER IS NOT WORKING. BATTERY MAY NEED TO BE REPLACED.

Comply By: 07/09/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

1. MICROWAVE IN THE KITCHEN IS OUT OF ORDER. 2. THERE IS A LIGHT BULB IN THE KITCHEN REFRIGERATOR THAT IS BROKEN/CRACKED.

Comply By: 07/16/24

Food and Equipment Temperatures

Type: Full
Date: *07/02/24*
Time: 11:00:00
Report: 8041241122
Merry Lake Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: GE REFRIGERATOR: PICO DE GALLO (RECENTLY PURCHASED)
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: GE REFRIGERATOR: AMBIENT AIR TEMP
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: GE REFRIGERATOR: MILK
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: GE REFRIGERATOR: BROTH
Violation Issued: Yes

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

Inspection was completed with Nash Omar. Peggy Anderson was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, solid surface countertop and wood flooring.

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has a Amana dishwasher that has a sani rinse/high temp cycle and achieved a temp at least 160F for sanitizing dishes.

GE refrigerator: picture of thermometer in cooler reading 39F sent to inspector after inspection and temperature in cooler was turned down. Continue to monitor the temperature of TCS foods in this cooler to ensure they are stored at 41F or below.

Discussed the following:
- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Pest control
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

Type: Full
Date: *07/02/24*
Time: 11:00:00
Report: 8041241122
Merry Lake Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041241122 of 07/02/24.

Certified Food Protection Manager: Lugman Abdirahman Ibrahim

Certification Number: fm117294 Expires: 05/04/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nash Omar
House Manager

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us