



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2024

Licensee
The Blessed Home Care
2441 Linwood Court East
Saint Paul, MN 55119

RE: Project Number(s) SL34027015

Dear Licensee:

On October 14, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 6, 2024, survey and the follow-up surveys completed on May 29, 2024, and August 12, 2024, were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jodi Johnson', with a stylized flourish at the end.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee
The Blessed Home Care
2441 Linwood Court East
Saint Paul, MN 55119

RE: Project Number(s) SL34027015

Dear Licensee:

On August 12, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 6, 2024, and the follow-up survey completed on May 29, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 6, 2024, found not corrected at the time of the August 12, 2024, follow-up survey and/or subject to penalty assessment are as follows:

- 1370 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (a)**
- 1380 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (b)**
- 1470 - Content Of Required Orientation - 144g.63 Subd. 2 - \$500.00**
- 1530 - Training In Dementia Care Required - 144g.64 - \$500.00**
- 1790 - Medication Management For Residents Who Will - 144g.71 Subd. 10 - \$500.00**
- 1940 - Individualized Treatment Or Therapy Managemen - 144g.72 Subd. 3 - \$500.00**
- 1970 - Treatment And Therapy Orders - 144g.72 Subd. 6 - \$500.00**
- 2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on August 12, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

- Level 1: no fines or enforcement.
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized

in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/12/2024
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34027015-2 On August 12, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 29, 2024. At the time of the survey, there were two residents; two receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued: 1370, 1380, 1470, 1530, 1790, 1940, 1970, 2310	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 780}	Continued From page 1 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	{0 790}			

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{0 790}	Continued From page 2 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action needed.	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action needed.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	{0 810}			

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{0 810}	Continued From page 3 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No futher action needed.	{0 810}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	{01370}			

Minnesota Department of Health

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{01370}	Continued From page 4 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) to include all required content.	{01370}			

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{01370}	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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on April 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them On August 12, 2024, at 11:04 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-E was trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's Staff Competency policy dated June 1, 2019, indicated the following topics would be completed by a practical skills test: -appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral	{01370}			

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{01370}	Continued From page 6 prosthetics), care and use of hearing aids, dressing and toileting -safe transfer techniques and ambulation -range of motion and positioning -reading and recording temperature, pulse and respirations -administration of medications and treatments, as required -other delegated tasks No further information was provided.	{01370}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-E) to	{01380}			

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{01380}	Continued From page 7 include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on April 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning On August 12, 2024, at 11:04 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-E was trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's Staff Competency policy dated June 1, 2019, indicated the following topics would be completed by a practical skills test: -appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting -safe transfer techniques and ambulation -range of motion and positioning	{01380}			

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{01380}	Continued From page 8	{01380}			
	No further information was provided.				
{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 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.	{01470}			

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{01470}	Continued From page 9 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-C, ULP-D and ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	{01470}			

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{01470}	Continued From page 10 The findings include: ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person ULP-D ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person ULP-E ULP-E was hired on April 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On August 12, 2024, at 11:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she thought supervising the ULP complete delegated tasks with each resident in the facility met the requirements for the required orientation content listed above.	{01470}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01470}	Continued From page 11 LALD/CNS-A further stated all ULP would be missing the required training as listed above. No further information was provided.	{01470}			
{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. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three	{01530}			

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{01530}	Continued From page 12 employees (unlicensed personnel (ULP)-C, ULP-D and ULP-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an Assisted Living license. ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record contained evidence the employee received six hours of dementia care training, and not the required eight hours of training within 160 working hours of the employment start date. ULP-D ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record contained evidence the employee received six hours of dementia care training, and not the required eight hours of training within 160 working hours of the employment start date.	{01530}			

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{01530}	Continued From page 13 ULP-E ULP-E was hired on April 12, 2024, to provide direct care and services to the facility's residents. ULP-E's employee record contained evidence the employee received four hours of dementia care training, and not the required eight hours of training within 160 working hours of the employment start date. On August 12, 2024, at 11:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were assigned only four hours of dementia care training upon hire and two additional hours of dementia training within six months of hire. LALD/CNS-A further stated the six hours of dementia training were the only trainings that were included in the modules she used. LALD/CNS-A further stated she would need to find additional sources of dementia care training for staff to meet the required eight hours. The licensee's Dementia Education policy dated June 1, 2019, indicated direct care employees must have completed at least four hours of initial education within 160 working hours of the employment start date. No further information was provided.	{01530}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to	{01790}			

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{01790}	Continued From page 14 exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that	{01790}			

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{01790}	Continued From page 15 medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for three of three unlicensed personnel (ULP-C, ULP-D and ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on August 21, 2023.	{01790}			

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{01790}	Continued From page 16 ULP-C's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. ULP-D ULP-D was hired on December 15, 2023. ULP-D's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. ULP-E ULP-E was hired on April 12, 2024. ULP-E's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. On August 12, 2024, at 11:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were trained and competency tested for providing medications for unplanned time away but did not document or include it in any of the staff files. The licensee's Staff Orientation and Education policy dated June 1, 20219, indicated the licensee would maintain proof of education in the personnel files. No further information provided.	{01790}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	{01940}			

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{01940}	Continued From page 17 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for the licensee's two residents (R3 and R4) who received treatments. This practice resulted in a level two violation (a	{01940}			

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{01940}	Continued From page 18 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 the potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). R3's service plan dated May 29, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's physician orders dated January 14, 2023, included oxygen administration up to 4 liters (L) leading into Trilogy machine to keep oxygen saturations above 92%., and pneumatic compression device to bilateral calves; remove 30 minutes twice a day. R3's record lacked physician orders for heel protectors and range of motion (ROM) exercises, blood pressure and pulse checks, and weight monitoring. R3's treatment plan dated April 5, 2024, indicated R3 received assistance with the following: -Trilogy Ventilation -ROM assistance daily	{01940}			

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{01940}	Continued From page 19 -Nebulizer PRN (as needed) for shortness of breath -Heel protectors when in bed -Oxygen 2-4 L ongoing -Oxygen Saturation every 4 hours and PRN -Skin check on bath days and every shift -Transfer to chair daily -Weekly Weight R3's treatment plan did not include daily blood pressure and pulse checks. In addition, R3's treatment plan failed to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 12, 2024, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she added weekly weights to R3's treatment plan after the previous survey on May 29, 2024, but missed adding the daily blood pressure and pulse checks. LALD/CNS-A further stated R3's treatment plan did not include the required content as listed above. R4 R4 was admitted March 16, 2022, with diagnoses that included right sided nontraumatic intracerebral hemorrhage (type of stroke that occurs when bleeding occurs in the brain's substance without trauma or surgery), left spastic hemiparesis (condition that causes abnormal	{01940}			

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{01940}	Continued From page 20 muscle stiffness and weakness on one side of the body) and anxiety. R4's service plan dated May 29, 2024, indicated R4 received assistance with oral care, grooming, continence care, dressing, bathing, active range of motion (ROM) exercises, positioning, transfers/mobility, behavior management, meal assistance, safety checks, daily blood pressure checks, weekly weights, tube feeding and medication management. R4's physician orders dated June 18, 2024, did not include orders for any or R4's treatments. R4's treatment plan dated April 25, 2024, indicated R4 received assistance with the following: -Passive ROM twice daily -Behavior Management every shift -Fluid Flush PEG Tube (feeding tube that is inserted through the abdomen and into the stomach) six times daily -PEG Tube Care three times daily -Tube Feeding three times daily and as needed R4's treatment plan did not include daily blood pressure checks or weekly weights. In addition, R4's treatment plan failed to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	{01940}			

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{01940}	Continued From page 21 On August 12, 2024, at 11:24 a.m., LALD/CNS-A stated R4's treatment plan did not include daily blood pressure checks or weekly weights. LALD/CNS-A further stated R4's treatment plan lacked the required content as listed above. The licensee's Treatment and Therapy Management policy dated June 1, 2019, indicated RN would complete a individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which would address: -the type of service to be provided -procedures for documenting treatments or therapies -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions -identification of treatment or therapy tasks delegated to unlicensed personnel -procedures for notifying the RN when a problem arises related to the treatment or therapy service. No further information was provided.	{01940}			
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced	{01970}			

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{01970}	Continued From page 22 by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's two residents (R3 and R4) receiving treatments. 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 the potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). R3's service plan dated May 29, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's treatment plan dated April 5, 2024, indicated R3 received assistance with the following: -Trilogy Ventilation -ROM assistance daily -Nebulizer PRN for shortness of breath -Heel protectors when in bed -Oxygen 2-4 L ongoing -Oxygen Saturation every 4 hours and as needed	{01970}			

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{01970}	Continued From page 23 (PRN) -Skin check on bath days and every shift -Transfer to chair daily -Weekly Weight R3's treatment plan did not include daily blood pressure and pulse checks. R3's physician orders dated January 14, 2023, included oxygen administration up to 4 liters (L) leading into Trilogy machine to keep oxygen saturations above 92%., and pneumatic compression device to bilateral calves; remove 30 minutes twice a day. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided updated physician orders for R3's medications and treatments dated June 18, 2024. However, the orders did not include any of R3's treatments. R3's record lacked physician orders for heel protectors, range of motion (ROM) exercises, blood pressure and pulse checks, and weight monitoring. R4 R4 was admitted March 16, 2022, with diagnoses that included right sided nontraumatic intracerebral hemorrhage (type of stroke that occurs when bleeding occurs in the brain's substance without trauma or surgery), left spastic hemiparesis (condition that causes abnormal muscle stiffness and weakness on one side of the body) and anxiety. R4's service plan dated May 29, 2024, indicated R4 received assistance with oral care, grooming, continence care, dressing, bathing, active range of motion (ROM) exercises, positioning, transfers/mobility, behavior management, meal	{01970}			

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{01970}	Continued From page 24 assistance, safety checks, daily blood pressure checks, weekly weights, tube feeding and medication management. R4's treatment plan dated April 25, 2024, indicated R4 received assistance with the following: -Passive ROM twice daily -Behavior Management every shift -Fluid Flush PEG Tube (feeding tube that is inserted through the abdomen and into the stomach) six times daily -PEG Tube Care three times daily -Tube Feeding three times daily and as needed R4's treatment plan did not include daily blood pressure checks or weekly weights. R4's physician orders dated March 30, 2022, included weekly blood pressure and weight checks, and PEG Tube care three times daily. LALD/CNS-A provided updated physician orders for R4's medications and treatments dated June 18, 2024. However, the orders did not include any of R4's treatments. On August 12, 2024, at 11:18 a.m., LALD/CNS-A stated she had received updated physician orders for R3 and R4 on June 18, 2024, but did not realize the treatments were not included in the physician orders until the surveyor reviewed the orders. LALD/CNS-A then sent R3 and R4's physician a request for all treatment orders which was received the afternoon of August 12, 2024, and emailed to the surveyor after the survey had concluded. The email contained signed physician orders dated August 12, 2024, for R3 and R4 which included orders for all treatments listed above.	{01970}			

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{01970}	Continued From page 25 The licensee's Treatment and Therapy management policy dated June 1, 2019, indicated the nurse would obtain orders or prescriptions for all treatments and therapies. The order would include the following elements: -resident name -description of the treatment or therapy to be provided -frequency -other pertinent information No further information was provided.	{01970}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for the licensee's two residents (R3 and R4) with side rails. 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 the potential to	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/12/2024
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119		
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{02310}	Continued From page 26 affect a large portion or all of the residents). The findings include: R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On August 12, 2024, at 9:30 a.m., they surveyor observed R3 lying in a hospital bed with bilateral upper side rails. R3's service plan dated May 29, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's Bed Safety Assessment dated April 29, 2024, indicated R3 utilized a hospital bed with bilateral siderails to assist turning and repositioning in bed. It also indicated R3 had been educated on the risks and benefits of using side rails. The assessment had measurements of the side rail for zone one but lacked measurements of the side rails zones two through four. R4 R4 was admitted March 16, 2022, with diagnoses that included right sided nontraumatic intracerebral hemorrhage (type of stroke that occurs when bleeding occurs in the brain's substance without trauma or surgery), left spastic hemiparesis (condition that causes abnormal muscle stiffness and weakness on one side of the body) and anxiety.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 27 On August 12, 2024, at 9:45 a.m., the surveyor observed R4 lying in a hospital bed with bilateral upper side rails. R4's service plan dated May 29, 2024, indicated R4 received assistance with oral care, grooming, continence care, dressing, bathing, active range of motion (ROM) exercises, positioning, transfers/mobility, behavior management, meal assistance, safety checks, daily blood pressure checks, weekly weights, tube feeding and medication management. R4's Side-Rail Use assessment dated March 17, 2022, indicated R4 utilized a hospital bed with bilateral siderails to assist turning and repositioning in bed. It also indicated R4 had been educated on the risks and benefits of using side rails. The assessment lacked measurements of the side rails zones one through four. On August 12, 2024, at 11:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not reassessed any of the resident's siderails since the previous follow up survey on May 29, 2024. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 28 the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 25, 2024

Licensee

The Blessed Home Care
2441 Linwood Court East
Saint Paul, MN 55119

RE: Project Number(s) SL34027015

Dear Licensee:

On May 29, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 6, 2024, found not corrected at the time of the May 29, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0900-Contract Required-144g.50 Subdivision 1
0950-Designation Of Representative-144g.50 Subd. 3
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - \$500.00
1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1970-Treatment And Therapy Orders-144g.72 Subd. 6
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on May 29, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 29, 2024, we identified the following violation(s):

1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)
1470-Content Of Required Orientation-144g.63 Subd. 2
1530-Training In Dementia Care Required-144g.64
1790-Medication Management For Residents Who Will-144g.71 Subd. 10

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. 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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

factor. to submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", is written over a faint, circular official stamp.

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

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2024
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34027015-1 On May 28, 2024, through May 29, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 6, 2024. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued 0630, 0660, 0900, 0950, 1640, 1880, 1940, 1970, 2310, and additional new orders were identified.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	{0 630}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 630}	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On March 29, 2024, at 10:04 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3.	{0 630}			

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{0 630}	Continued From page 2 R3's service plan dated May 28, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's IAPP dated April 29, 2024, indicated R3 was not at risk to be abused. The licensee failed to recognize that R3 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize her abuse by others including other vulnerable adults. In addition, the area for "client at risk for abusing other vulnerable adults" was left blank. On May 29, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R3's IAPP should have reflected R3 as a vulnerable adult. LALD/CNS-A further stated she must have accidentally left the area for R3 being at risk for abusing others blank. The licensee's Vulnerable Adult/Child Protection policy dated June 1, 2019, indicated the licensee would assess vulnerability status of each resident upon admission. Susceptibility to abuse includes self-abuse and neglect and risk of abuse by other individuals, including other vulnerable adults or minors and the resident's risk of abusing other vulnerable adults within the residence. It further indicated the IAPP would contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults/minors. No further information was provided.	{0 630}			

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{0 660}	Continued From page 3	{0 660}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-D). 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	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 4 situation has occurred only occasionally). The findings include: ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record contained a clinical document that indicated ULP-D had a "positive TB Gold; no symptoms, nonspecific reaction to cell mediated im". The clinical document also indicated ULP-D had a negative chest x-ray indicating no evidence of active tuberculosis. However, ULP-D's employee record lacked evidence of a TB history and symptom screening. On March 29, 2024, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-D's employee record did not include a TB history and symptom screening. The licensee's Tuberculosis Screening/Prevention policy dated June 1, 2019, indicated employees would receive a baseline TB screening upon hire to test for infection with M. tuberculosis. No further information was provided.	{0 660}			
{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	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 5 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	{0 790}			

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{0 790}	Continued From page 6 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action needed	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action needed	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 7 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed	{0 810}			
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management	{0 900}			

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NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119		
(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	
{0 900}	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	{0 900}			

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{0 900}	Continued From page 9 The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's record lacked a written contract. On May 29, 2024, at 8:47 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's representative was emailed R1's contract but has been out of the country and had not returned the contract yet. No further information was provided.	{0 900}			
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	{0 950}			

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{0 950}	Continued From page 10 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R1 and R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1's record lacked evidence of a contract. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated	{0 950}			

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{0 950}	Continued From page 11 Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R3 R3's Assisted Living contract dated October 12, 2021, lacked the required notice to designate a representative. R3's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On May 29, 2024, at 8:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was waiting for the consultant to provide updated documents to include the required content listed above. LALD/CNS-A further stated all resident contracts would need to be updated. No further information was provided.	{0 950}			

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01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01370			

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01370	Continued From page 13 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them ULP-D	01370			

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01370	Continued From page 14 ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record lacked evidence of competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them On May 29, 2024, at 9:37 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D were trained and competent in all the areas listed above, but their record lacked evidence of competencies. The licensee's Staff Competency policy dated June 1, 2019, indicated the following topics would be completed by a practical skills test: -appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting -safe transfer techniques and ambulation -range of motion and positioning -reading and recording temperature, pulse and respirations -administration of medications and treatments, as required	01370			

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01370	Continued From page 15 -other delegated tasks No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01380			

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01380	Continued From page 16 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: ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning ULP-D ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record lacked evidence of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning On May 29, 2024, at 9:37 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D were trained and competent in all the areas listed	01380			

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01380	Continued From page 17 above, but their record lacked evidence of competencies. The licensee's Staff Competency policy dated June 1, 2019, indicated the following topics would be completed by a practical skills test: -appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting -safe transfer techniques and ambulation -range of motion and positioning -reading and recording temperature, pulse and respirations -administration of medications and treatments, as required -other delegated tasks No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=E	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);	01470			

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01470	Continued From page 18 (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 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	01470			

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01470	Continued From page 19 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 two of two employees (unlicensed personnel (ULP)-C and ULP-D) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person ULP-D ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents.	01470			

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01470	Continued From page 20 On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On May 29, 2024, at 9:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D's records lacked the required training as listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
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	01530			

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01530	Continued From page 21 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an Assisted Living license. ULP-C ULP-C was hired on August 21, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record contained evidence the employee received four hours of dementia care	01530			

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01530	Continued From page 22 training, and not the required eight hours of training within 160 working hours of the employment start date. ULP-D ULP-D was hired on December 15, 2023, to provide direct care and services to the facility's residents. On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record contained evidence the employee received four hours of dementia care training, and not the required eight hours of training within 160 working hours of the employment start date. On May 29, 2024, at 9:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were assigned only four hours of dementia care training. LALD/CNS-A further stated she did not know of the eight hour training requirement. The licensee's Dementia Education policy dated June 1, 2019, indicated direct care employees must have completed at least four hours of initial education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}			

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{01640}	Continued From page 23 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all of the residents).	{01640}			

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{01640}	Continued From page 24 The findings include: R1 R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's service plan dated May 3, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. R1's undated and unsigned, home health care plan indicated R1 received assistance with dressing, grooming, catheter care, mobility/transfers and feeding assistance. R1's service plan was not signed by R1's representative or by the licensee. R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. R3's service plan dated May 28, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management.	{01640}			

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{01640}	Continued From page 25 R3's service plan was not signed by R3 or by the licensee. On May 29, 2024, at 8:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not updated R1's service plan because she was waiting for his annual re-assessment date to update all of his documents. LALD/CNS-A further stated she recently became aware of the service plan document in the electronic health record (EHR) she used and was updating the form to have the residents or resident representatives sign but had not completed this yet so none of the three residents had a signed service plan. The licensee's Service Plan policy dated June 1, 2019, indicated the service plan would include a description of the services to be provided. It further indicated it would be signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided.	{01640}			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790			

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01790	Continued From page 26 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790			

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01790	Continued From page 27 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP-C, ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on August 21, 2023. ULP-C's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available.	01790			

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01790	Continued From page 28 ULP-D ULP-D was hired on December 15, 2023. On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. On May 29, 2024, at 9:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were trained and competency tested for providing medications for unplanned time away but did not document or include it in any of the staff files. The licensee's Staff Orientation and Education policy dated June 1, 20219, indicated the licensee would maintain proof of education in the personnel files. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
{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	{01880}			

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{01880}	Continued From page 29 review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all 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) 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 March 28, 2024, at 9:43 a.m., the surveyor observed the unattended medication cabinet open with the key still in the lock. On March 29, 2024, at 10:04 a.m., the surveyor observed unlicensed personnel (ULP)-D remove R3's medications from the medication cabinet in the kitchen to prepare them for administration. ULP-D brought R3's medications to her in her bedroom, leaving the key to the medication cabinet in the lock. The medication cabinet was left unsecured and unattended for approximately five minutes. On March 28, 2024, at 9:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had educated all staff after the initial survey regarding security of medications. LALD/CNS-A further stated the key should never be left in the lock without staff present and she expected the medication cabinets to be secured at all times when not in use.	{01880}			

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{01880}	Continued From page 30 The licensee's Storage/Control of Medications policy dated June 1, 2019, indicated medications were stored in a secured medication cabinet and only authorized nursing personnel had access to the locked cabinet. No further information provided.	{01880}			
{01940} SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	{01940}			

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{01940}	Continued From page 31 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's service plan dated May 3, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. R1's physician orders dated January 17, 2024,	{01940}			

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{01940}	Continued From page 32 included blood sugar checks twice a day, water flushes per gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach) four times a day. R1's record lacked physician orders for range of motion exercises, blood pressure checks, and weight monitoring. R1's treatment plan dated March 14, 2023, indicated R1 received assistance with the following: -passive range of motion (ROM) twice daily -G-tube cares twice daily -PEG tube fluid flush every six hours -Blood sugar checks twice a day R1's treatment plan did not include blood pressure checks or weight monitoring. In addition, R1's treatment plan failed to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. R3's service plan dated May 28, 2024, indicated	{01940}			

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{01940}	Continued From page 33 R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's physician orders dated January 14, 2023, included oxygen administration up to 4 liters (L) leading into Trilogy machine to keep oxygen saturations above 92%., and pneumatic compression device to bilateral calves; remove 30 minutes twice a day. R3's record lacked physician orders for heel protectors and range of motion (ROM) exercises, blood pressure and pulse checks, and weight monitoring. R3's treatment plan dated April 5, 2024, indicated R3 received assistance with the following: -Trilogy Ventilation -ROM assistance daily -Nebulizer PRN for shortness of breath -Heel protectors when in bed -Oxygen 2-4 L ongoing -Oxygen Saturation every 4 hours and as needed (PRN) -Skin check on bath days and every shift R3's treatment plan did not include daily blood pressure and pulse checks, weekly weights, or compression device to bilateral calves. In addition, R3's treatment plan failed to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - any resident-specific requirements relating to	{01940}			

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{01940}	Continued From page 34 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 29, 2024, at 8:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had updated R1 and R3's treatment plan after the licensee's initial survey and thought she included all the required content. LALD/CNS-A further stated R1 and R3's treatment plans did not include all treatment services being provided and lacked the required content as listed above. The licensee's Treatment and Therapy Management policy dated June 1, 2019, indicated RN would complete a individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which would address: -the type of service to be provided -procedures for documenting treatments or therapies -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions -identification of treatment or therapy tasks delegated to unlicensed personnel -procedures for notifying the RN when a problem arises related to the treatment or therapy service. No further information was provided.	{01940}			
{01970} SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized	{01970}			

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{01970}	Continued From page 35 prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1 and R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's service plan dated May 3, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording	{01970}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/29/2024
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
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{01970}	Continued From page 36 intake and output, weight monitoring, tube feeding and medication administration. R1's physician orders dated January 17, 2024, included blood sugar checks twice a day, water flushes per gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach) four times a day. R1's record lacked physician orders for range of motion exercises, blood pressure checks, and weight monitoring. R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On March 29, 2024, at 9:58 a.m., the surveyor observed ULP-D check R3's blood pressure, pulse, and oxygen saturation. R3's service plan dated May 28, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. R3's physician orders dated January 14, 2023, included oxygen administration up to 4 liters (L) leading into Trilogy machine to keep oxygen saturations above 92%, and pneumatic compression device to bilateral calves; remove 30 minutes twice a day. R3's record lacked physician orders for heel protectors, range of motion (ROM) exercises, blood pressure and pulse checks, and weight	{01970}			

Minnesota Department of Health

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{01970}	Continued From page 37 monitoring. On May 39, 2024, at 8:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R3's records lacked physician orders for the treatments listed above. LALD/CNS-A further stated she had not requested updated physician orders for R1 as she was waiting for his annual re-assessment date to update all of his assessments and orders. Furthermore, LALD/CNS-A stated R3 did not use bilateral compression device but instead wore heel protectors. LALD/CNS-A stated she had missed requesting updated physician orders for all treatments being provided to R3. The licensee's Treatment and Therapy management policy dated June 1, 2019, indicated the nurse would obtain orders or prescriptions for all treatments and therapies. The order would include the following elements: -resident name -description of the treatment or therapy to be provided -frequency -other pertinent information No further information was provided.	{01970}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 38 by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R1 and R3) with side rails. 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's service plan dated May 3, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. On May 28, 2024, at 10:00 a.m., R1's room was observed to have a hospital bed with bilateral upper side rails. R1's comprehensive assessment dated April 29, 2024, indicated R1 utilized a hospital bed with bilateral siderails to assist with bed mobility. It	{02310}			

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{02310}	Continued From page 39 also indicated R1 had been educated on the risks and benefits of using side rails. The assessment had measurements of the side rail for zone one but lacked measurements of the side rails zones two through four. R3 R3 was admitted on November 22, 2019, with diagnoses that included multiple sclerosis (a chronic disease of the nervous system). On March 29, 2024, at 10:04 a.m., the surveyor observed ULP-D administer medications to R3. R3's service plan dated May 28, 2024, indicated R3 received assistance with oral care, dressing, bathing, skin care, transfer assistance, safety checks, behavior management, daily blood pressure and pulse checks, oxygen saturation checks seven times a day, weekly weights, trilogy management and medication management. On May 28, 2024, at 10:10 a.m., R3's room was observed to have a hospital bed with bilateral upper side rails. R3's comprehensive assessment dated April 29, 2024, indicated R1 utilized a hospital bed with bilateral siderails to assist turning and repositioning in bed. It also indicated R1 had been educated on the risks and benefits of using side rails. The assessment had measurements of the side rail for zone one but lacked measurements of the side rails zones two through four. On May 29, 2024, at 8:48 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she didn't measure zones two through four because R1 and R3 had	{02310}			

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{02310}	Continued From page 40 different side rails then what was shown on the brochure she referenced for measuring zones. LALD/CNS-A further stated the licensee's third resident had side rails and zones two through four were not measured for her either. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 3, 2024

Licensee
The Blessed Home Care
2441 Linwood Court East
Saint Paul, MN 55119

RE: Project Number(s) SL34027015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34027015 On March 4, 2024, through March 6, 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 three residents; three receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On March 4, 2024, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/CNS-A currently held a LALD license effective through October 31, 2024; however, LALD/CNS-A's license lacked an organization listed as the Director of Record for the licensee. On March 4, 2024, at 11:30 a.m. the evaluator emailed a BELTSS representative to clarify LALD/CNS-A's status as director of record for the facility. At 12:27 p.m., the BELTSS representative stated LALD/CNS-A was not listed as Director of Record for the licensee.	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 On March 4, 2024, at 3:29 p.m. LALD/CNS-A indicated she was not aware that she wasn't listed as the Director of Record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 4, 2024, at 10:50 a.m., registered nurse (RN)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.	0 250			

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0 250	Continued From page 5 - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent,	0 250			

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NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
(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
0 250	Continued From page 6 I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by the licensee's agent on July 20, 2023. The licensee had an assisted living license issued on August 1, 2023, with an expiration date of July 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how	0 250			

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0 250	Continued From page 7 changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management As a result of this survey, the following orders were issued 0550, 0630, 0660, 1620, 1700, 1880,1940, 1970, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470			

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0 470	Continued From page 8 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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held and assisted living license. The facility was licensed for a capacity of four and had	0 470			

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0 470	Continued From page 9 a current census of three residents. During the entrance conference on March 4, 2024, at 10:00 a.m., the surveyor did not observe the daily staffing schedule. On March 4, 2024, at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee posted a two-week staffing schedule instead of a daily staffing schedule and did not have a staffing plan. No further information was provided. TIME PERIOD OF 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	0 480			

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0 480	Continued From page 10 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 6, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 550			

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0 550	Continued From page 11 review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 March 4, 2024, at 10:00 a.m. during the facility tour, the surveyor did not observe any signage or information posted regarding the grievance procedure, and the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On March 4, 2024, at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the grievance procedure was reviewed with the residents at the time of admission. LALD/CNS-A further stated the grievance procedure had been posted at the front entrance, but they recently had the walls painted and it must not have been put back up. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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0 630	Continued From page 12	0 630			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes.	0 630			

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0 630	Continued From page 13 R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. On March 4, 2024, at 11:56 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications. R1's IAPP dated March 5, 2023, indicated R1 was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually) by others. However, it did not include the following required items: - the resident's risk of abusing other vulnerable adults; - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 5, 2024, at 10:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed R1's IAPP and stated R1's IAPP did not include R1's risk of abusing other vulnerable adults and interventions for identified vulnerability. The licensee's Vulnerable Adult/Child Protection policy dated June 1, 2019, indicated the licensee would assess vulnerability status of each resident upon admission. Susceptibility to abuse includes self-abuse and neglect and risk of abuse by other individuals, including other vulnerable adults or minors and the resident's risk of abusing other vulnerable adults within the residence. It further indicated the IAPP would contain statements of	0 630			

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0 630	Continued From page 14 specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults/minors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a facility tuberculosis (TB) risk assessment. This practice resulted in a level two violation (a violation that did no 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	0 660			

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0 660	Continued From page 15 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at 2:11 p.m., the surveyor requested the licensee's TB risk assessment. On March 5, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had a TB risk assessment completed but it was located in her home office which could not be accessed during the survey. The licensee's Tuberculosis Screening/Prevention policy dated June 1, 2019, indicated the licensee would complete a TB prevention plan and risk assessment. 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;	0 680			

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0 680	Continued From page 16 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following: - establish and maintain a comprehensive EPP,	0 680			

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0 680	Continued From page 17 reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - community risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe	0 680			

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0 680	Continued From page 18 evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - entities providing services under agreement; - residents' physicians; - volunteers; - communication plan must include contact information for: - other sources of assistance; - communication plan must include: - means to provide information about facility occupancy; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include a method for sharing information from emergency plan;	0 680			

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0 680	Continued From page 19 - must develop and maintain EP training and testing program, review/update annually; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On March 6, 2024, at 8:37 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license's current EP plan did not include the above content. LALD/CNS-A further stated EP is an area she has not really worked on yet. The licensee's Emergency Preparedness policy dated June 1, 2019, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency disaster or disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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	0 720			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 720	Continued From page 20 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 records were readily available for access to the commissioner upon request. 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 March 4, 2024, at 8:09 a.m., the surveyor attempted to call the telephone number available to announce the survey. There was no answer; however, the surveyor was able to leave a voicemail message. -at 8:18 a.m., the surveyor sent an email to facility email address, with information regarding the survey. The email requested the current resident roster, discharged resident roster, and employee list be ready for the surveyor upon arrival at the facility; indicated there would be an entrance conference to review expectations for the survey, and to have the registered nurse available at the time of survey. -at 9:30 a.m., upon the surveyor's entrance to the facility, unlicensed personnel (ULP) were on-site and stated they had not heard anything from	0 720			

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0 720	Continued From page 21 licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A or the registered nurse (RN) and were not aware of the surveyor's planned arrival. ULP-C stated she would send a message to LALD/CNS-A and call RN-B to notify them of the surveyor's arrival. -9:51 a.m., the surveyor spoke with RN-B who stated LALD/CNS-A was on vacation. RN-B stated she would come to the facility for the entrance conference. -at 10:50 a.m. during the entrance conference, RN-B stated she did not have access to personnel records. -at 11:15 a.m., LALD/CNS-A emailed the surveyor and stated all personnel records were located at her home office and since she was on vacation, the records would not be available during the survey. The licensee's Request for Records policy dated June 1, 20219, indicated the licensee would comply with written requests for copies of records or a summary of the information in the records unless such information is detrimental to the resident's physical or mental health or would cause him or her to harm himself or herself or another. The policy lacked verbiage when dealing with the commissioner's agents. 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	0 780			

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0 780	Continued From page 22 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 780			

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0 780	Continued From page 23 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 March 5, 2024, at 9:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-C. During the tour, survey staff observed the following: 1. When the smoke alarm installed outside the sleeping areas was tested, none of the other smoke alarms in the dwelling unit were activated. 2. When smoke alarms installed in resident bedrooms 1, 2, 3, and 4 were tested, none of the other smoke alarms in the dwelling unit were activated. 3. The smoke alarm in the basement did not work when tested, smoke alarm interconnection could not be verified at the time of the facility tour. Properly maintained smoke alarms play a crucial role in providing early warning of a fire to the building occupants. During the facility tour interview on March 5, 2024, ULP-C verified the smoke alarms were not testing as interconnected and that the smoke alarm in the basement was not working. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790			

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0 790	Continued From page 24 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 5, 2024, at 9:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-C. During the tour, survey staff observed the following: 1. A tag or label was not attached to the portable fire extinguisher installed in the dining area showing annual maintenance had been performed by certified service personnel. 2. A tag or label was not attached to the portable fire extinguisher installed in the dining area showing monthly inspections had been	0 790			

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0 790	Continued From page 25 completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on March 5, 2024, ULP-C verified tags or labels were not attached to the portable fire extinguisher showing annual maintenance and monthly inspections had been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide 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, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800			

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0 800	Continued From page 26 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 March 5, 2024, at 9:00 a.m., survey staff toured the home with unlicensed personnel (ULP)-C. During the tour, survey staff observed the following: 1. ULP-C was unable to open the egress windows at the start of the facility tour in occupied resident bedrooms 1 and 2. During the facility tour interview on March 5, 2024, ULP-C verified the windows would not open. ULP-B stated the windows had been recently painted and weatherstripping had been installed. Egress windows that do not work properly could delay escape in the event of an emergency. The licensee failed to maintain egress windows in a continuous state of good repair and operation. 2. An exit sign was posted over the door leading into the garage from the home. This door was also labeled as an exit on the evacuation floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 3. The posted evacuation floor plan was not accurate; it did not include the basement. 4. Ceiling tiles were missing in the basement mechanical room. During the facility tour interview on March 5, 2024, ULP-C verified the door leading into the garage was designated as an emergency exit, the basement floor plan was not posted, and ceiling	0 800			

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0 800	Continued From page 27 tiles were missing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810			

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0 810	Continued From page 28 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 4, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP). FIRE SAFETY AND EVACUATION PLAN The FSEP fire safety policy dated August 1, 2021, was a template and had not been developed for use at this facility. The FSEP facility diagram and evacuation plan were blank. The FSEP fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP referenced pull fire alarms, which were not observed on the facility tour. The FSEP fire safety policy did not identify	0 810			

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0 810	Continued From page 29 specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The FSEP fire safety policy directs employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. The FSEP failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including the unique needs of residents evident by a lack of these procedures in the plan. On March 4, 2024, at 9:50 a.m., survey staff emailed the licensee requesting documentation be provided no later than 9:00 a.m. on March 5, 2024, for the following: 1. Documentation of employee training on the FSEP completed within the last year. 2. Documentation of resident training on fire safety and evacuation completed within the last year. 3. Documentation of evacuation drills completed since licensure (08/01/2021). As of March 7, 2024, at 4:00 p.m., no documentation was received on employee training, resident training, and evacuation drills. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. Record review indicated the licensee failed to provide training to residents on the proper actions to take in the event of a fire at least once per year as evident by the lack of training documentation. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by the lack of	0 810			

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0 810	Continued From page 30 documentation. On March 4, 2024, at 9:50 a.m., survey staff emailed the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A requesting a phone call for March 5, 2024, at 11:00 a.m. LALD/CNS-A did not respond to this request for a phone exit interview. On March 5, 2024, at 11:17 a.m., survey staff emailed LALD/CNS-A a summary of the physical environment survey findings. On March 5, 2024, at 1:15 p.m., LALD/CNS-A confirmed receipt of this email. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900			

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0 900	Continued From page 31 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's record lacked a written contract. On March 4, 2024, at 5:41 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's family member signed	0 900			

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0 900	Continued From page 32 the contract for R1, and it should have been in R1's record but was unsure why it could not be located. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950			

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0 950	Continued From page 33 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's record lacked evidence of a contract. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a copy of the contract used for all residents, which lacked the required notice to designate a representative. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not	0 950			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 950	Continued From page 34 take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On March 6, 2024, at 7:31 a.m., LALD/CNS-A stated all resident contracts would need to be updated to include the required content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01620 SS=D	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	01620			

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01620	Continued From page 35 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. R1's ongoing nursing assessments were requested. Assessments dated June 10, 2023, September 15, 2023, and January 18, 2024, were	01620			

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01620	Continued From page 36 provided. The September 15, 2023, assessment was done 97 days after the date of the previous assessment, exceeding 90 calendar days. The January 18, 2024, assessment was done 125 days after the date of the previous assessment, exceeding 90 calendar days. On March 4, 2024, at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's September and January assessment exceeded 90 days from the previous assessment. The licensee's Assessment-Comprehensive Services policy dated June 1, 2019, indicated ongoing resident monitoring and reassessment must be conducted as needed based on changes in the needs of the resident, but cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640			

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01640	Continued From page 37 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. On March 5, 2024, at 7:56 a.m., the surveyor	01640			

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01640	Continued From page 38 observed unlicensed personnel (ULP)-D administer medications to R1 and check his blood sugar. R1's service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. R1's undated and unsigned, home health care plan indicated R1 received assistance with dressing, grooming, catheter care, mobility/transfers and feeding assistance. R1's service plan was not signed by R1's representative or by the licensee. On March 5, 2024, at 4:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's service plan did not include all the services provided. LALD/CNS-A further stated R1's signed service plan should have been placed in R1's hard chart and does not know why it could not be located. The licensee's Service Plan policy dated June 1, 2019, indicated the service plan would include a description of the services to be provided. It further indicated it would be signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment which included the required content for one of one resident (R1).	01700			

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01700	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with medication administration. On March 4, 2024, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's signed prescriber orders dated January 17, 2024, included: -amlodipine 5 milligrams (mg) (for blood pressure) -apixaban 5 mg (for atrial fibrillation) -acetaminophen 1,000 mg (for pain) -aluminum-magnesium hydroxide 200-200 mg/5 milliliters (ml) (for stomach upset) -ascorbic acid 1,000 mg (supplement) -Baclofen 5 mg (muscle relaxant) -bisacodyl 10 mg suppository (for constipation) -brimonidine 0.2% (eye drops) -creon 6,000-19,000-30,000 units (for gastrostomy tube obstruction) -diclofenac 1% gel (for pain)	01700			

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01700	Continued From page 41 -dorzolamide-timolol 2-0.5% (eye drop) -Imodium 2 mg (for loose stools) -menthol 4% gel (for pain) -Metformin 500 mg (for diabetes) -metoprolol tartrate 50 mg (for atrial fibrillation) -Nystatin 100000 unit/ml (for skin irritation) -oxycodone 5 mg (for pain) -polyethylene glycol 17 grams (for constipation) -prednisolone acetate 1% (eye drop) -sennosides 8.6 mg (for constipation) -sodium bicarbonate 650 mg (for gastrostomy tube obstruction) -Vitamin D2 1,250 micrograms (mcg) (supplement) -aspirin 81 mg (preventative medication) -atorvastatin 40 mg (for cholesterol) -Melatonin 5 mg (for sleep) R1's medication assessment dated February 28, 2023, failed to identify the following: - an identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and - the licensee provided instructions to the resident and legal or designated representative on interventions to manage the resident's medications and prevent diversion of medications. On March 5, 2024, at 1:11 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's record lacked a medication management assessment to include all the required content as noted above.	01700			

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01700	Continued From page 42 The license's Assessment for Medication Management Program policy dated June 1, 2019, indicated the medication assessment would include the following elements: -identification of all medications, including over-the-counter and herbal/dietary supplements -medication reconciliation, including indication for medications, effectiveness of drug therapy, side effects, immediate desired effects, unusual and unexpected effects, actual or potential drug interactions, duplicate drug therapy, non-adherence with drug therapy, drug therapy currently associated with laboratory monitoring, allergic reactions, change in condition that contraindicate continued administration of the medication -potential for diversion of medication by the client or others with access to it. (The risk (high, moderate or low risk) for diversion would be measured according to the following criteria: controlled substances being used by resident, location of residence, presence of other residents or visitors to home with access to medications, other risk factors/lack of protection of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the	01710			

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01710	Continued From page 43 resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an annual reassessment of the resident's medication management services for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. On March 4, 2024, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with medication administration. R1's medication assessment dated February 28, 2023, indicated R1 required assistance with medication administration and insulin.	01710			

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01710	Continued From page 44 R1's record lacked evidence of any additional medication management assessments. On March 5, 2024, at 1:11 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not completed an annual reassessment of R1's medication management services. The licensee's Assessment for Medication Management Program policy dated June 1, 2019, indicated the medication reassessment would occur at the following times: -resident symptomology -problems or concerns that may be medication-related -with new prescription, over the counter or herbal products -annually No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
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 medications were secure and permitted access to only	01880			

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01880	Continued From page 45 authorized personnel for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 March 4, 2024, at 10:00 a.m. during the facility tour with unlicensed personnel (ULP)-C, the surveyor was shown multiple cabinets in the kitchen where all resident's medications were stored. ULP-C opened the unlocked cabinets to show the surveyor the medications. -at 10:50 a.m. during the entrance conference, registered nurse (RN)-B stated all medications were secured in the locked cabinets located in the kitchen. -at 11:56 a.m., the surveyor observed ULP-C removed R1's medications from the unlocked medication cabinets in the kitchen to prepare them for administration. ULP-C brought R1's medications to him in his bedroom, leaving the medication cabinets unsecured and unattended. While observing ULP-C administer R1 his medications, the surveyor noted two bottles of Melatonin, one bottle of D-Mannose Urinary support, one bottle of dorzolamide/timolol eye drops and a bottle of brimonidine tartrate eye drops on his table. At this time, R1 stated the bottles were his vitamins that the ULP gave him	01880			

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01880	Continued From page 46 at night, and they administered those eye drops throughout the day. -at 12:05 p.m., the surveyor inquired if the medication cabinets should be locked, and ULP-C indicated they have locks on them, but staff did not lock them. ULP-C further stated the medication in R1's room has always been kept there. -at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the medication cabinets should be locked at all times. LALD/CNS-A further stated only skin creams and eye drops were kept in R1's room because they were used four times a day or more. The licensee's Storage/Control of Medications policy dated June 1, 2019, indicated medications were stored in a secured medication cabinet and only authorized nursing personnel had access to the locked cabinet. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940			

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01940	Continued From page 47 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01940			

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01940	Continued From page 48 situation has occurred only occasionally). The findings include: During the entrance conference on March 4, 2024, at 10:50 a.m., registered nurse (RN)-B stated the licensee provided treatment management services to their residents. R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. On March 5, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 and check his blood sugar. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding and medication administration. R1's physician orders dated January 17, 2024, included blood sugar checks twice a day, water flushes per gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach) four times a day. R1's record lacked physician orders for range of motion exercises, blood pressure checks, and weight monitoring. R1's records lacked a treatment management plan to include the following required content for treatments provided to R1: - statement of the type of service that will be	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 49 provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 5, 2024, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's treatment plan should have been in his hard chart and did not know why it could not be located. The licensee's Treatment and Therapy Management policy dated June 1, 2019, indicated RN would complete a individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services which would address: -the type of service to be provided -procedures for documenting treatments or therapies -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions -identification of treatment or therapy tasks delegated to unlicensed personnel -procedures for notifying the RN when a problem arises related to the treatment or therapy service. No further information was provided.	01940			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
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01940	Continued From page 50	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 22, 2022, with diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso)	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
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01970	Continued From page 51 and diabetes. On March 5, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 and check his blood sugar. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises twice a day, blood pressure checks twice a day, blood sugar checks twice a day, weekly weight monitoring, and tube feeding flushes nine times a day. R1's physician orders dated January 17, 2024, indicated blood sugar checks twice a day, water flushes per gastrostomy tube (G-tube) (tube inserted through the belly that brings nutrition directly to the stomach) four times a day. R1's record lacked physician orders for range of motion exercises, blood pressure checks and weight monitoring. On March 6, 2024, at 2:06 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had an order from R1's primary physician for range of motion exercises, blood pressure checks, weight monitoring and for the water flushes per G-tube for six times a day. However, the licensee did not provide the order to the surveyor. The licensee's Treatment and Therapy management policy dated June 1, 2019, indicated the nurse would obtain orders or prescriptions for all treatments and therapies. The order would include the following elements: -resident name -description of the treatment or therapy to be	01970			

Minnesota Department of Health

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01970	Continued From page 52 provided -frequency -other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with side rails. 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 the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on November 22, 2022, with	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
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02310	Continued From page 53 diagnoses that included quadriplegia (form of paralysis that affects all four limbs, plus the torso) and diabetes. R1's unsigned, service plan dated February 19, 2024, indicated R1 received assistance with active range of motion exercises, appointment reminder/assistance, bathing assistance, blood pressure checks, blood sugar checks, recording intake and output, weight monitoring, tube feeding, and medication administration. On March 4, 2024, at 10:10 a.m., R1's room was observed to have a hospital bed with bilateral upper side rails. R1 stated the side rails were used to assist with repositioning while in bed. R1's comprehensive assessment dated December 22, 2022, indicated R1 utilized a hospital bed with bilateral siderails to assist turning and repositioning in bed. It also indicated R1 had been educated on the risks and benefits of using side rails. The assessment lacked documentation of the measurements of the side rails zones one through four. On March 4, 2024, at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all three of their residents had hospital beds with side rails and the licensee had not measured the side rail zones for any of them. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems	02310			

Minnesota Department of Health

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02310	Continued From page 54 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	03090			

Minnesota Department of Health

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03090	Continued From page 55 failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on March 4, 2024, at 10:00 a.m., the surveyor observed the incorrect electronic monitoring notice posted at the entrance to the licensee's facility, which read: "No Trespassing, 24-hour video surveillance." On March 4, 2024, at 3:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the sign was posted at the front door did not include the following statement "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 03/06/24
Time: 11:45:33
Report: 1023241044

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Blessed Home Care
2441 Linwood Court East
St Paul, MN55119
Ramsey County, 62

Establishment Info:

ID #: 0038298
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512107190
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) **** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOOD STORED OVER READY TO EAT FOODS SUCH AS RAW SHELL OVER FRUIT AND VEGETABLES. OPERATOR MOVED EGGS TO SAFE LOCATION DURING INSPECTION.

Comply By: 03/06/24

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE DEVICE TO VERIFY DISH MACHINE TEMP AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Comply By: 03/06/24

2-100 Supervision

2-102.12AMN

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

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:

<https://fmctraining.web.health.state.mn.us/search/index.cfm>

Comply By: 03/06/24

Type: Full
Date: 03/06/24
Time: 11:45:33
Report: 1023241044
The Blessed Home Care

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

Type: Full
Date: 03/06/24
Time: 11:45:33
Report: 1023241044
The Blessed Home Care

Food and Beverage Establishment Inspection Report

Page 3

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 1023241044 of 03/06/24.

Certified Food Protection Manager: JOVELINE OBAY

Certification Number: SERVESAF Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

STAFF
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us