DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 20, 2023

Licensee
Great Home Minnesota LLC
8668 Alvarado Court
Inver Grove Heights, MN 55077

RE: Initial License Number 408920
Health Facility Identification Number (HFID) 35520
Project Number(s) SL35520015

Dear Licensee:

On February 15, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed October 28, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 28, 2023.

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the October 28, 2022, initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 28, 2022, found not corrected at the time of the February 15, 2023, follow-up evaluation and subject to a penalty assessment are as follows:

1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1820-Prescriptions-144g.71 Subd. 13
2320-Appropriate Care And Services-144g.91 Subd. 4 (b) - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the

correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. The licensee is not required to submit a plan of correction 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).

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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

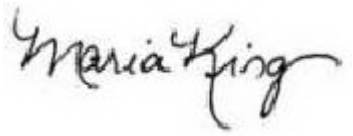
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jonathan Hill at 651-201-3993.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35520	A. BUILDING: _____ B. WING _____	R 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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: Project SL35520015-1 On February 13, through February 15, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 28, 2022. At the time of the survey, there were 3 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No Further Action Needed	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	{0 780}		

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{0 780}	Continued From page 2 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 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}		
{0 810} 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	{0 810}		

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{0 810}	Continued From page 3 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}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	{01440}		

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{01440}	Continued From page 4 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two unlicensed personnel (ULP)-C, and 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) 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: ULP-C was hired October 16, 2021, and provided direct care services for the residents of the facility. ULP-D was hired January 6, 2021, and provided direct care services for the residents of the	{01440}		

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{01440}	Continued From page 5 facility. On February 14, 2023, at 9:19 a.m., during an observation of cares, ULP-C was observed to transfer R2 from bed to wheelchair using a mechanical lift. On October 25, 2022, at 8:15 a.m., during the original survey, ULP-D was observed administering medications to R4. ULP-C and ULP-D's records lacked documentation the RN completed a 30-day supervision of ULP-C or ULP-D performing delegated tasks. On February 14, 2023, at 1:01 p.m., RN-A stated she "provided the education" and watched caregivers administer medications, but did not document. The licensee's correction order documentation indicated, "initial supervisions done" dated January 6, 2023. No further documentation was provided to indicate which ULPs or what tasks were observed. The licensee's Supervision: Unlicensed Staff policy, dated February 1, 2023, indicated, "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance", "Supervision includes direct observation of the home health aide while the home health aide is providing services and will be provided as frequently as needed based on the home health aide's competence and performance", and "Supervision includes verification that the work is being performed	{01440}		

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{01440}	Continued From page 6 competently and problems/solutions related to the home health aide's ability to perform the tasks are identified". No further information was provided.	{01440}		
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a current written service plan for two of three residents (R1, R4). This practice resulted in a level two violation (a	{01640}		

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{01640}	Continued From page 7 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's record included an assisted living contract signed October 31, 2022. The contract included a service plan, indicating R1 received services including COVID-19 diagnostic test, weekly on Thursday mornings. The service plan lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: i. the action to be taken if the scheduled service cannot be provided; ii. information and a method to contact the facility; iii. the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and iv. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01640}		

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{01640}	Continued From page 8	{01640}		

R4
R4's record included an assisted living contract signed August 15, 2021. The contract included a service plan, indicating R4 received services including COVID-19 diagnostic test, weekly on Thursday mornings. The service plan lacked the following required content:
-the schedule and methods of monitoring assessments of the resident;
-the schedule and methods of monitoring staff providing services; and
-a contingency plan that includes:
i. the action to be taken if the scheduled service cannot be provided;
ii. information and a method to contact the facility;
iii. the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
iv. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

On February 13, 2023, at 3:00 p.m., administrator (A)-B stated R1 and R4 were no longer being tested weekly for COVID-19, and the service plans needed to be updated. A-B further stated he would print updated service plans and have them signed.

On February 14, 2023, at 2:11 p.m., consulting registered nurse (CRN)-F stated, during her visits with the licensee, she instructed registered nurse (RN)-A (also the licensed assisted living director)

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{01640}	Continued From page 9 to update the residents' service plans, but to her knowledge, it had not yet been completed. The licensee's Service Plan policy dated February 1, 2023, indicated "The service plan must be revised, if needed, based on resident review or reassessment", and "The initial service plan and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided." The policy further indicated, "The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; c. The identification of the staff or categories of staff who will provide the services; d. The schedule and methods of monitoring reviews or assessments of the resident; e. The schedule and method of monitoring staff providing services; and f. A contingency plan that includes the following: i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or resident's representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and	{01640}		

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{01640}	Continued From page 10 declarations made by the resident related to health care directives". No further information was provided.	{01640}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accurate documentation of medication administration for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	{01760}		

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{01760}	Continued From page 11 The findings include: R4 had diagnoses including depression and schizophrenia. R4's service plan, dated August 15, 2021, indicated R4 received services including assistance with medication administration. R4's comprehensive nursing assessment, dated February 3, 2023, indicated R4 needed full assistance with medication management. R4's record included an unsigned pharmacy medication order list, dated January 2023 including the following medications: -vitamin D3 (supplement) 50 micrograms (mcg), take one tablet by mouth, once daily; -atorvastatin (for high cholesterol) 20 milligrams (mg), take one tablet by mouth at bedtime; -lisinopril (for blood pressure) 5 mg, take one tablet by mouth at bedtime; -carvedilol (for blood pressure) 6.25 mg, one tablet twice daily; -amlodipine besylate (for blood pressure) 10 mg, one tablet by mouth once daily; -trazodone (an antidepressant) 100 mg, take one tablet by mouth at bedtime; and -triamcinolone acetonide (for itching and irritation of the skin) 0.1% cream, apply topically to rash on arms three times daily. R4's medication administration record (MAR) for February 1-13, 2023, lacked documentation the following medications were administered or reason why they were not administered at the following scheduled times: -vitamin D 50 mcg, give one tablet by mouth once daily: February 1-12, 8:00 a.m.; -atorvastatin 20 mg, give one tablet by mouth	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35520	A. BUILDING: _____ B. WING _____	R 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

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{01760}	Continued From page 12 once daily at bedtime: February 6, bedtime; -lisinopril 5 mg, one tablet by mouth daily at bedtime: February 6, bedtime; and -carvedilol 6.25 mg, one tablet twice daily: February 6, bedtime. R4's MAR lacked any documentation of administration of trazodone, and triamcinolone acetonide cream, as were indicated as current medications on the pharmacy medication list. R4's MAR for February 1-13, 2023, indicated R4 was administered amlodipine besylate 10 mg, one tablet at 8:00 a.m., once daily, but lacked a route of administration. The MAR further lacked a route of administration for carvedilol, and indicated carvedilol was incorrectly administered a second time in the a.m. on February 6 and 8. R4's record lacked signed prescriber orders indicating any medications for R4 had been discontinued. On February 14, 2023, at 10:59 a.m., ULP-C stated R4 had not been administered vitamin D "for a long time". On February 14, 2023, at 11:36 a.m. RN-A (who is also the licensed assisted living director) stated when a resident had a new order or a change in dose, it was automatically sent to the pharmacy, who then would supply the correct medications. RN-A stated the pharmacy sometimes would send the signed orders to her, that the pharmacy had the orders, and she did not have signed orders for all medications. RN-A further stated she was still learning how to enter medications correctly into the electronic MAR. The licensee's Medication Documentation policy,	{01760}		

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{01760}	Continued From page 13 dated February 1, 2023, indicated, "Each medication administered by [licensee] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Residents' needs will be met related to the Medication Management Plan." The policy further indicated, "Complete documentation of medication administration includes the following: a. Resident's name; b. Medication name; c. Medication dosage; d. Date and time of administration; e. Method/route of administration; and f. Signature and Title of staff administering the medication". The policy further indicated, "If the administration of one or more medications was not completed, staff will document the following: a. The reason why the medication was not administered; b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan; c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages; d. Medication Error report, if appropriate". No further information provided	{01760}		
{01820} SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced	{01820}		

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{01820}	Continued From page 14	{01820}		

by:
Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R2, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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:

R2
R2 had diagnoses including dwarfism, intellectual/developmental disability, and obesity.

R2's comprehensive nursing assessment, dated February 7, 2023, indicated R2 needed full assistance with medication management.

R2's medication administration record (MAR) for February 1-13, 2023, indicated R2 was administered the following medication:
-levothyroxine (for thyroid) 75 mcg, one tablet by mouth once daily at 8:00 a.m.

On February 14, 2023, at 10:59 a.m., ULP-C accessed R2's electronic MAR. The MAR was observed to include the following medications available to be administered to R2 as needed: lotrimin (clotrimazole-antifungal cream), senna (for constipation), and seroquel (quetiapine-an antipsychotic). ULP-C stated R2 was no longer administered the as-needed medications, and

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{01820}	Continued From page 15 further stated seroquel was not available to be administered. R2's record lacked signed orders prescribing or discontinuing the levothyroxine, lotrimin, senna, and seroquel. R4 R4 had diagnoses including depression and schizophrenia. R4's service plan, dated August 15, 2021, indicated R4 received services including assistance with medication administration. R4's comprehensive nursing assessment, dated February 3, 2023, indicated R4 needed full assistance with medication management. R4's medication administration record (MAR) for February 1-13, 2023, indicated R4 was administered the following medications: -amlodipine besylate (for blood pressure) 10 milligrams (mg), one tablet at 8:00 a.m., once daily; -aspirin 81 mg, one tablet by mouth once daily; -carvedilol (for blood pressure) 6.25 mg, one tablet twice daily; -spironolactone (for blood pressure) 25 mg, one tablet by mouth once daily at bedtime; -vitamin D (supplement) 50 mcg, give one tablet by mouth once daily; -bacitracin zinc (to prevent/treat skin infections) 500 units (u)/gram (g), apply topically to affected area one to two times daily, cover with band-aid; -clonidine (for blood pressure) 0.3 mg/24 hours, apply patch to skin weekly on Thursday; -atorvastatin (for cholesterol) 20 mg, give one tablet by mouth once daily at bedtime; and -lisinopril (for blood pressure) 5 mg, one tablet by	{01820}		

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{01820}	Continued From page 16 mouth daily at bedtime. R4's record included an unsigned pharmacy medication order list, dated January 2023 that included the following additional medications which were not present in the MAR and not administered: -trazodone (an antidepressant) 100 mg, take one tablet by mouth at bedtime; and -triamcinolone acetonide (for itching and irritation of the skin) 0.1% cream, apply topically to rash on arms three times daily. R4's record lacked signed prescriber orders for the above-listed medications. On February 14, 2023, at 11:36 a.m. RN-A (who is also the licensed assisted living director) stated when a resident had a new order or a change in dose, it was automatically sent to the pharmacy, who then would supply the correct medications. RN-A stated the pharmacy sometimes would send the signed orders to her, that the pharmacy had the orders, and she did not have signed orders for all medications. The licensee's Medication Orders policy, dated February 1, 2023, indicated, "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation." No further information was provided.	{01820}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}		

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{02040}	Continued From page 17 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No Further Action Needed	{02040}		
{02320} SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services during use of a mechanical lift for one of one resident (R3). This resulted in an immediate order issued on October 25, 2022, at 12:42 p.m. A follow-up revisit indicated the licensee failed to fully correct the deficiency by providing re-education to staff on safe usage of	{02320}		

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{02320}	Continued From page 18	{02320}		

the mechanical lift. This had the potential to affect one of one resident (R2) who required the use of a mechanical lift for transfer.

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:

R2 had diagnoses including dwarfism, intellectual/developmental disability, and obesity.

R2's comprehensive nursing assessment, dated February 7, 2023, indicated R2 used a mechanical lift with assistance of two caregivers for transfers from bed to wheelchair, and to a shower chair for bathing.

On February 14, 2023, at 9:19 a.m., during an observation of cares, unlicensed personnel (ULP)-C and registered nurse (RN)-E transferred R2 from bed to wheelchair using a mechanical lift.
-ULP-C stated caregivers transfer R2 into his wheelchair with the mechanical lift, and for bathing, caregivers wheel R2 into the shower room in his wheelchair and transfer with a 2 person lift into the shower chair.

ULP-C's record included documentation of online training completed January 20, 2023, titled lifting and safe transfers, but did not indicate training was provided specific to the mechanical lift used for R2, or an observation of competency by the

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{02320}	Continued From page 19 RN. On February 14, 2023, at 12:40 p.m., RN-A stated staff completed training on the mechanical lift through online education. RN-A further stated she did not document any in-person training or competency with staff using the mechanical lift since the last survey. On February 14, 2023, at 12:50 p.m., ULP-C stated she completed an online course on use of the mechanical lift. ULP-C further stated it had been a long time since she had in person training on the mechanical lift or observation by the RN. On February 14, 2023, at 2:11 p.m., consulting RN (CRN)-F stated, during her visits with the licensee, she had not provided or seen documentation of additional training or competency, provided to staff by the RN, on use of R2's mechanical lift. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated, "A registered nurse or licensed health professional at [licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act." No further information was provided.	{02320}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered
November 30, 2022

Administrator
Great Home Minnesota LLC
8668 Alvarado Court
Inver Grove Heights, MN 55077

RE: Conditional License Number 408920
Health Facility Identification Number (HFID) 35520
Project Number(s) SL35520015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on October 28, 2022 for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **February 28, 2023**.

Licensing Orders

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

Imposition of Fines

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts ofeither $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under thischapter for the same circumstance.

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

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00
St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $9,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Documentation of Action to Comply
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
b. Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
c. 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is

substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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 (but not both) 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.

Conditional License Issued:
MDH will issue Great Home Minnesota LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Great Home Minnesota LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Great Home Minnesota LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Great Home Minnesota LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Great Home Minnesota LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Great Home Minnesota LLC will contract with an RN to provide consultation concerning all resident(s) to whom Great Home Minnesota LLC

provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Great Home Minnesota Llc. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Great Home Minnesota LLC and MDH must review the RN's credentials and approve the selection. Great Home Minnesota Llc is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Great Home Minnesota LLC in an effort to help Great Home Minnesota LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Great Home Minnesota LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Great Home Minnesota LLC and the RN consultant about a change. Each report will be electronically submitted to Jonathan Hill, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jonathan.hill@state.mn.us. Jonathan Hill can be reached at 651-201-3993 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Great Home Minnesota LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Great Home Minnesota LLC in meeting the needs of the people it serves. In addition, the Office of

Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Great Home Minnesota LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Great Home Minnesota LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Great Home Minnesota LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Great Home Minnesota LLC's assisted living facility license, and Great Home Minnesota LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Great Home Minnesota LLC is not in substantial compliance, MDH may take additional enforcement action against Great Home Minnesota LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jonathan Hill directly at: 651-201-3993.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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	35520	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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 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: SL35520015 On, October 24 through October 28, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom received services under the provider's Assisted Living with Dementia Care license. This resulted in issuing immediate correction orders for 2310 on October 24, 2022, at 3:45 p.m. and for 2320 on October 25, 2022, at 12:42 p.m. At the time of exit on October 28, 2022, at 10:38 a.m., the immediacies for 2310 and 2320 were not removed.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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 access according to section 256.9742, subdivision 4; (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	0 250		

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0 250	Continued From page 2 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, observation 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 with records reviewed. 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 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: The licensee had an assisted living license issued on August 1, 2021, and renewal effective August 1, 2022, with an expiration date of January 31, 2023.	0 250		

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0 250	Continued From page 3 The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis (TB) and COVID-19, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. The licensee's Application for Assisted living License, signed May 17, 2021, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), indicated, "I certify I have read and understand the following:" A check mark, indicating understanding, 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.	0 250		

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0 250	Continued From page 4 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - 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	0 250		

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0 250	Continued From page 5 are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, 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 five was electronically signed by owner, LALD/RN-A on May 17, 2021. The licensee's renewal application signed by owner, A-B on June 1, 2022, also indicated check marks attesting A-B understood Assisted Living Licensure laws, rules and statutes, as listed above. The renewal application further indicated A-B understood A-B was "legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract."	0 250		

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0 250	Continued From page 6 During the entrance conference on October 24, 2022, at 11:25 a.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A, and administrator (A)-B, stated they were in charge of the day to day operations of the facility and were familiar with the regulations for an Assisted Living with Dementia Care. LALD/RN-A and A-B further stated the licensee provided the following services: medication and treatment management, staff orientation and training, and delegation of tasks by the RN to ULPs. The licensee failed to implement the corresponding policies and procedures, as required. As a result of this survey, 45 correction orders were issued: 250, 0430, 0470, 0480, 0490, 0510, 0550, 0580, 0630, 0640, 0650, 0660, 0680, 0730, 0780, 0790, 0810, 900, 0950, 1440, 1460, 1500, 1610, 1620, 1640, 1700, 1730, 1760, 1820, 1880, 1890, 1910, 1940, 1950, 1960, 1970, 2040, 2090, 2110, 2140, 2240, 2260, 2310, 2320, 3090, 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		
0 430 SS=E	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted	0 430		

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0 430	Continued From page 7 living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 and R3's record lacked evidence of a signature from the resident or resident's	0 430		

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0 430	Continued From page 8 representative indicating that a UDALSA was provided, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and -an oral explanation of the services offered under the contract. R1 R1's record indicated R1 received services for medication administration, meals, housekeeping and laundry. R1's record lacked documentation of receipt of the UDALSA. R3 R3's record indicated R3 received services for assistance with activities of daily living (ADLs), medication administration, meal assistance, housekeeping and laundry. R3's record included a UDALSA which was undated and lacked R3's signature. On October 25, 2022, at 9:04 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated they were not aware R1 required a new UDALSA since R1 had been admitted after residing in one of the licensee's other facilities. On October 25, 2022, at 12:30 p.m., LALD/RN-A provided an unsigned contract dated August 22,	0 430		

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0 430	Continued From page 9 2022, for R1, but the contract lacked a UDALSA. On October 26, 2022, at 1:12 p.m., LALD/RN-A stated a signed UDALSA should have been in both R1 and R3's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 10 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. This had the potential to affect all four 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: The licensee converted to an assisted living license on August 1, 2021. On October 24, 2022, at 11:20 a.m., during the entrance conference, the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated she thought administrator (A)-B kept the staffing plan electronically. On October 24, 2022, at 3:15 p.m., the staffing plan was requested from LALD/RN-A, but not provided. The licensee's Staffing and Scheduling policy, dated August 1, 2021, indicated, "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the	0 470		

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0 470	Continued From page 11 residents' needs 24-hours a day, seven-days a week." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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. The facility also failed to ensure food menus were prepared and made available for residents no less than one week in advance. This had the potential to affect all residents of the assisted living facility.	0 480		

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0 480	Continued From page 12	0 480		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

On October 24, 2022, from 11:05 a.m. through 3:05 p.m., it was observed the facility lacked a posted menu.

On October 24, 2022, at 2:40 p.m., R1 stated staff informed her of what the meals were if she asked, but had never been provided a weekly menu since arriving at the facility. R1 stated she was not aware of a menu being posted.

On October 24, 2022, at 3:05 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated they did not have a menu posted but had one they kept on a clipboard. LALD/RN-A provided a transparent pink clipboard which included two weekly schedules for meals, both were undated and incomplete. LALD/RN-A stated the menus were incomplete, and were not posted or distributed to residents. LALD/RN-A stated the clipboard was not available to residents. LALD/RN-A further stated she was not aware a completed menu was required to be posted and available to residents in the facility.

On October 26, 2022, at 9:51 a.m., R4 stated she did not always know ahead of time what meals would be served. R4 stated the menu was

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0 480	Continued From page 13 sometimes posted on the refrigerator but usually was not. R4 stated she had never been provided with a weekly menu she could keep in her room. The licensee's Food Service and Menu Planning policy dated August 1, 2021, indicated, "Menus will be prepared at least one (1) week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning." Please also refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 22, 2022, for additional specified Minnesota Food Code deficiencies. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;	0 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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
0 490	Continued From page 14 (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a daily program of social and recreational activities that were based upon individual and group interests or physical, mental, and psychosocial needs. This had the potential to affect all four residents 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) 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 October 24, 2022, at 11:20 a.m., during the entrance conference, the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated they had not developed a schedule of daily activities for the facility. LALD/RN-A further stated when activities were planned for residents of the licensee's other facility, the residents from this facility were included.	0 490		

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0 490	Continued From page 15 On October 24, 2022, at 4:50 p.m., the common area of the home was observed to lack a posted schedule of activities. On October 26, 2022, during a 9:50 a.m. interview, R3 stated, "the truth is we pretty much watch [television] because LALD/RN-A is so busy all the time with other things. I know she is trying to do her best, but still." On October 26, 2022, during a 9:51 a.m. interview, R4 stated staff rarely take the residents on outings. R4 further stated they have attended holiday parties at a sister facility, and one time they went apple-picking, but they had not done any other activities in a while. R4 added she had never seen a posted activity schedule in the facility. On October 26, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C stated they did not have a planned schedule of activities for the residents. ULP-C indicated activities were not observed over the recent days because staff were too busy with the survey. ULP-C stated activities included movies, singing karaoke, or R1 and R4 could go for walks, but R2 and R3 could not due to their mobility limitations. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
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	0 550		

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0 550	Continued From page 16 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Office of Mental Health and Developmental Disabilities (OMHDD). This had the potential to affect all four residents receiving assisted living 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) 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 October 24, 2022, at 4:50 p.m., common areas of the home were observed to lack a posting of the licensee's grievance procedure. On October 25, 2022, at 8:29 a.m. ULP-C verified the grievance procedure was not posted on the facility bulletin board or in another common area	0 550		

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0 550	Continued From page 17 of the facility. On October 25, 2022, at 10:07 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the grievance procedure was posted at their other facilities, but must not have been put up at this location. LALD/RN-A provided the surveyor a copy of the complaint/grievance procedure and a blank grievance form. The licensee's complaint/grievance posting policy, dated July 22, 2021, indicated LALD/RN-A was responsible for handling complaints/grievances. The policy further indicated, "[Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." The policy further indicated, "The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes	0 580		

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0 580	Continued From page 18 in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 11, 2022, at 11:57 a.m., during the entrance conference, the surveyor requested documentation of quality management activities. Licensed Assisted Living Director, who was also the registered nurse (LALD/RN)-A stated she discussed quality management topics often with the owner and with unlicensed personnel (ULP)-B (House Manager), but had not documented any of the meetings or a current quality improvement project.	0 580		

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0 580	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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).	0 630		

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0 630	Continued From page 20 The findings include: R1 R1's record indicated R1 received services including assistance with medication administration, meals, housekeeping and laundry. On October 25, 2022, at 9:04 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated she had not completed an IAPP for R1 upon admission to the facility. LALD/RN-A stated she did not think an IAPP needed to be completed since R1 had been admitted after residing in one of the licensee's other facilities. On October 25, 2022, at 11:55 a.m., LALD/RN-A provided a nursing assessment for R1 completed during survey on October 25, 2022. The document included a safety assessment that indicated R1 was at risk to be abused and to abuse others. The assessment lacked statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. R3 R3's record indicated R3 received services including assistance with activities of daily living (ADLs), medication administration, meal assistance, housekeeping and laundry. R3's record included an undated IAPP that indicated R3 was at risk to be abused and needed to be supervised at home and in the community. The IAPP lacked: -an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults;	0 630		

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0 630	Continued From page 21 -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. LALD/RN-A provided an updated IAPP for R3, completed on October 24, 2022, during the survey. The updated IAPP further indicated R3 was at risk to abuse others verbally, but lacked specific measures to be taken to minimize the identified risk. The licensee's Vulnerable Adult Maltreatment -Prevention and Reporting policy, dated August 1, 2021, indicated, "[Licensee] also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640		

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0 640	Continued From page 22 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all four 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 the potential to affect a large portion or all the residents). The findings include: On October 24th, 2022, at 12:45 p.m., the common area of the facility was observed to lack a posting of information and numbers for reporting to MAARC. Licensed assisted living director/registered nurse (LALD/RN)-A, stated MAARC contact information was not posted in the facility. LALD/RN-A indicated they needed to post it. LALD/RN-A stated she thought possibly it was taken down when they painted the walls and was not replaced. The licensee's Vulnerable Adult Maltreatment - Prevention and Reporting policy, dated August 1, 2021, indicated, "[Licensee] will post information for reporting suspected crime and maltreatment." No further information was provided.	0 640		

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0 640	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 24 by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content 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) 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-D was hired on January 6, 2021. PERFORMANCE REVIEW ULP-D's employee record lacked documentation of an annual performance evaluation. On October 25, 2022, at 1:56 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated she completed a performance review for ULP-D, and it was documented on paper, but would be located at her other office. LALD/RN-A stated she would try to get it to the surveyor. The performance review was not provided. TRAINING ULP-D's employee record lacked documentation of training and competency evaluation for delegated treatments provided for R3, including gentamicin (an antibiotic) bladder irrigation and urinary catheterization (a procedure to empty urine from the bladder).	0 650		

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0 650	Continued From page 25 On October 26, 2022, during a 9:50 a.m. interview, R3 stated staff, including ULP-D, administered a gentamicin bladder irrigation every night before bed. R3 further stated LALD/RN-A trained ULP-D on both the gentamicin bladder irrigation as well as a urinary catheterization procedure with R3. On October 26, 2022, at 11:16 a.m., ULP-D stated LALD/RN-A trained her on both the gentamicin bladder irrigation and straight catheterization procedures for R3, and LALD/RN-A observed her performing the procedures. On October 26, 2022, during a 12:56 p.m. interview, LALD/RN-A indicated ULP-D's catheterization and bladder irrigation training was documented on paper. LALD/RN-A stated, "I think it is in my file". The documentation was not provided. The licensee's Employee Records policy, dated August 1, 2021, indicated the employee record would include, "Records of all training and in-service education required and/or provided including record of competency testing as required", and "Documentation of annual performance reviews that identify areas of improvement needed and training needs". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 26 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT On October 24, 2022, at 11:25 a.m., during the	0 660		

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0 660	Continued From page 27 entrance conference, the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated they had not completed a Facility TB Risk Assessment. LALD/RN-A stated she was not sure what risk level the facility was at. On October 24, 2022, at 3:45 p.m., LALD/RN-A provided a TB Screening and Prevention policy dated April 1, 2017. LALD/RN-A stated she had the TB Risk Assessment but was unable to locate it. On October 25, 2022, at 12:00 p.m., LALD/RN-A provided a blank TB Risk Assessment worksheet. On October 25, 2022, at 3:02 p.m., LALD/RN-A stated she thought she had completed the TB Risk Assessment. LALD/RN-A LALD/RN-A was hired on July 15, 2010, and provided supervisory and direct cares for the residents of the facility. LALD/RN-A's employee record lacked documentation of a baseline TB test, and TB history and symptom screening, completed prior to providing assisted living services. ULP-D ULP-D was hired on January 6, 2021, and provided direct cares for the residents of the facility. ULP-D's employee record included documentation of a negative TB blood test completed January 15, 2021, but lacked documentation of TB history and symptom screening completed upon hire.	0 660		

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	35520	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

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0 660	Continued From page 28 On October 25, 2022, at 3:07 p.m., LALD/RN-A stated her TB test results were not in her employee file but were in another file. The surveyor requested the other file, but was not provided. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's TB Screening/Prevention policy dated April 1, 2017, indicated, "[Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: risk assessment, frequency of screening, serial testing and staff education." 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	0 680		

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0 680	Continued From page 29 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all four 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	0 680		

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0 680	Continued From page 30 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 October 24, 2022, the licensee provided an, "Emergency Plan," policy/procedure, dated May 22, 2021, and lacked required information and customization to the licensee; 16 pages of the policy/procedure were provided, however the glossary indicated there should have been at least 20 pages. On October 26, 2022, the licensee provided an, "Emergency Preparedness Plan -Appendix Z Compliance," policy dated August 1, 2021. The above provided EP plan, policies and procedures lacked individualized emergency procedures to include the following: - establish and maintain a comprehensive EP, 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; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans);	0 680		

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0 680	Continued From page 31 - missing resident plan; - 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; - sewage and waste disposal; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - evacuation location; - 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;	0 680		

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0 680	Continued From page 32 - 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 policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; - other sources of assistance; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance;	0 680		

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0 680	Continued From page 33 - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - 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 October 26, 2022, at 1:25 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated the EP plan was missing required content. LALD/RN-A stated she must have forgotten to review the EP plan annually. LALD/RN-A stated she needed a guide or resource to develop the EP plan correctly. The licensee's "Emergency Preparedness Plan -Appendix Z Compliance," policy dated August 1, 2021, indicated, "[Licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an	0 680		

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0 680	Continued From page 34 all-hazards approach. Key elements of the plan include four primary components: risk assessment and planning, policies and procedures, a communication plan, staff training and exercises/drills." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (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;	0 780		

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0 780	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the smoke alarms outside within the immediate vicinity of sleeping rooms and the interconnection of required smoke alarms in the home. This has the potential to directly affect 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 October 27, 2022, approximately from 10:30 a.m. to 12:00 p.m., survey staff toured the home with administrator (A)-B. During the tour of the three-story home with four designated resident bedrooms (#1 through #4), survey staff observed and A-B verified the following: 1) The hallways of the lower-level outside vicinity of resident sleeping rooms #1, #2, #3, and #4, and the hallway outside of the bedroom on the main level next to the kitchen/dining side did not have the required smoke alarms. A-B confirmed the findings and asked if the existing smoke alarm located in the middle next to the living/dining area would be acceptable to meet the requirement for bedrooms #1 through #4. Survey staff explained that the smoke alarms must be located within the immediate vicinity of the bedrooms for proper notification, and the existing smoke alarm near the living room did not meet the requirement.	0 780		

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0 780	Continued From page 36 2) The testing of smoke alarms failed to activate all smoke alarms throughout the home as required for interconnection of all smoke alarms for proper notification. The finding was evident when the smoke alarms in the administrator's master bedroom on the main level, the outside hallway vicinity of the master bedroom, and the smoke alarm inside the upper-level bedroom did not sound when the lower-level smoke alarms were tested. A-B verified some smoke alarms were not interconnected. He stated that he would replace the smoke alarms. On October 27, 2022, at approximately 12:30 p.m., during the exit interview, A-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the minimum required size of portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On October 27, 2022, approximately from 10:30 a.m. to 12:00 p.m., survey staff toured the three-story home with administrator (A)-B. During the tour, survey staff observed portable fire extinguishers located on the lower-level floor and the main level floor did not meet the minimum required size rating of 2-A:10-B:C and in addition, were not mounted as required. The portable fire extinguishers had a label with rated type 1-A:10-B:C. A-B verified the findings and asked for additional information on the minimum size rating. On October 27, 2022, at approximately 12:30 p.m. during the exit interview, A-B acknowledged the findings. No further information was provided.	0 790		

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0 790	Continued From page 38 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
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 drill.	0 810		

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0 810	Continued From page 39 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on the fire safety and evacuation plan, and the minimum number of fire and evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, 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 October 27, 2022, at approximately 12:00 p.m., survey staff reviewed the licensee's fire safety and evacuation documentation and related documentation provided for review. Document review and interview with administrator (A)-B at approximately 12:30 p.m. indicated the following: FIRE SAFETY AND EVACUATION PLAN 1) The floor plan layout lacked the number and location of resident sleeping rooms. 2)The plan documentation lacked fire protection procedures for residents. 3) The plan documentation did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency.	0 810		

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0 810	Continued From page 40 4) The home's fire policy, dated August 1, 2021, lacked site-specific fire protection procedures. The documentation had incorrect procedures that included a fire sprinkler system by indicating that sprinklers will be activated as necessary. In addition, the procedures also referred to magnetic holders for fire doors which the home did not have. DRILLS Documentation review indicated there no fire and evacuation drill records were available for review. Administrator (A)-B asked licensed assisted living director (LALD)/registered nurse (RN)-A about the drill records and LALD/RN-A stated they had been performing drills but had not recorded them. Survey staff explained to A-B and LALD/RN-A that their policy, dated August 1, 2021, had adopted the correct minimum required number of fire safety and evacuation drills twice per year per shift, with at least one evacuation drill every other month for a total minimum of six drills, but they will need to carry out the drills and maintain records to show compliance with the requirement. LALD/RN-A and A-B confirmed the finding. TRAINING 1) Documentation review indicated the licensee lacked documentation of employee training on the fire safety and evacuation plan completed upon hire and twice per year thereafter. No training records were provided for review. 2) Document review indicated that the licensee did not provide annual training to residents who could assist in their evacuation or the proper actions to take in the event of a fire, including: movement, evacuation, or relocation. No resident training records were provided for review. On October 27, 2022, at approximately 12:45	0 810		

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0 810	Continued From page 41 p.m., during the exit interview, A-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	0 900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

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0 900	Continued From page 42 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 a written and signed assisted living contract with the required content for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's record lacked a resident signed contract prior to the start of services. On October 24, 2022, at 2:40 p.m., R1 stated she did not remember if she signed a contract when admitted to the facility. On October 25, 2022, at 8:42 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated she had a contract for R1.	0 900		

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0 900	Continued From page 43 On October 25, 2022, at 9:04 a.m., LALD/RN-A, stated R1 was transferred from one of their other facilities and was not aware a new contract was required. On October 25, 2022, at 11:46 a.m., LALD/RN-A provided a copy of R1's contract and stated it had not been signed by R1. The contract included the first 19 pages of a 53 pages document. LALD/RN-A stated she did not believe a new contract needed to be signed since R1 was not a new admission rather a transfer from one of their other facilities. R3 R3's record lacked a resident signed contract prior to the start of services. On October 26, 2022, at 9:50 a.m., R3 stated he had not signed a contract when admitted to the facility. On October 26, 2022, at 1:23 p.m., LALD/RN-A provided a copy of R3's contract and stated it could not be signed by R3 until his case manager reviewed it. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated when a prospective resident decides to move into the facility, an Assisted Living contract is signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 950	Continued From page 44	0 950		
0 950 SS=E	144.50 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 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 offer the opportunity to identify a designated representative for two of two residents (R1, R3).	0 950		

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0 950	Continued From page 45 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 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 and R3's records both lacked documentation the residents were presented with the required verbatim notice indicating their "Right to designate a representative for certain purposes" and given the opportunity to identify a designated representative. On October 24, 2022, at 2:40 p.m., R1 stated she did not remember if she signed a designated representative form. On October 25, 2022, at 12:30 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated there was no signed document which would have allow R1 the opportunity to identify a designated representative. LALD/RN-A stated she did not believe one needed to be signed since R1 was not a new admission but rather a transfer from one of their other facilities. On October 26, 2022, at 9:50 a.m., R3 stated he had not signed any documents when admitted to the facility. The licensee's Designated Representative policy dated August 1, 2021, indicated, "Before or at the time of execution of an assisted living contract,	0 950		

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0 950	Continued From page 46 [licensee] will offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form will be kept in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 47 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one unlicensed staff (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) 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-D was hired January 6, 2021, and provided direct care services for the residents of the facility. ULP-D's employee record indicated ULP-D completed medication administration training on January 11, 2021. On October 25, 2022, at 8:15 a.m., the surveyor observed ULP-D administer medications to R4. ULP-D's record lacked documentation the RN completed a 30-day supervision of ULP-D performing delegated tasks. On October 25, 2022, at 1:10 p.m., ULP-D verified she completed the training indicated on the undated training and competency form. ULP-D further indicated she was observed later (30-day supervision), but did not know who did it	01440		

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01440	Continued From page 48 or if it was documented. On October 25, 2022, at 1:56 p.m., licensed assisted living director/registered nurse (LALD/RN) stated all training and observation should be located in the employee file. LALD/RN-A further stated she observed ULPs frequently because she was in the home often, and she either did not document it or the form was in her files. The licensee's Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated, "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." The policy further stated documentation of supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another	01460		

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01460	Continued From page 49 facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed orientation to assisted living facility licensing requirements and regulations before providing services 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee converted to an Assisted Living license on August 1, 2021 ULP-D was hired January 6, 2021, and provided direct care services for the residents of the facility. ULP-D's employee record lacked documentation of updated orientation to the following assisted living topics: - Overview of Assisted Living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the	01460		

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01460	Continued From page 50 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On October 25, 2022, at 8:36 a.m. ULP-D stated she had orientation when she started, and licensed assisted living director/registered nurse (LALD/RN)-A provided all training. On October 25, 2022, at 1:10 p.m., ULP-D stated she had renewed orientation when the new assisted living licensure took effect August 1, 2021. ULP-D did not know if the orientation was documented. On October 25, 2022, at 1:56 p.m., LALD/RN-A stated she provided new orientation to staff after the new licensure, and thought it was documented in the employee binder. Documentation was not provided.	01460		

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01460	Continued From page 51 The licensee's Orientation of Staff and Supervisors and Content policy, dated August 1, 2021, indicated, "All staff of [licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500		

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01500	Continued From page 52 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two	01500		

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01500	Continued From page 53 employees (unlicensed personnel (ULP)-D) with records reviewed. 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: ULP-D was hired January 6, 2021, and began providing assisted living services August 1, 2021. On October 25, 2022, at 8:15 a.m., the surveyor observed ULP-D administer medications to R4. ULP-D's employee record lacked documentation of 8 hours of annual training completed within the last year, including the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500		

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01500	Continued From page 54 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On October 25, 2022, at 8:36 a.m. ULP-D stated licensed assisted living director/registered nurse (LALD/RN)-A provided the required training. On October 25, 2022, at 12:35 p.m., LALD/RN-A stated she provided all training topics to staff. LALD/RN-A stated the documentation should be in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01610		

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01610	Continued From page 55 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed an initial comprehensive nursing assessment prior to signing the assisted living contract/providing services for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 received services including assistance with medication administration, meals, housekeeping and laundry. R1's record lacked an initial RN assessment completed prior to the initiation of services. On October 24, 2022, at 2:40 p.m., R1 stated a pre-admission assessment with a RN had not occurred. On October 25, 2022, at 9:04 a.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated R1 was transferred from one of their other facilities and was not aware new RN assessments were required.	01610		

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01610	Continued From page 56 On October 25, 2022, at 11:46 a.m., LALD/RN-A provided an admission RN assessment for R1 completed on October 25, 2022, during survey. R3 R3 received services including assistance with activities of daily living (ADLs), medication administration, meal assistance, housekeeping and laundry. R3's record included an undated document titled Admission Assessment. The document included a medication list, but lacked documentation of a nursing assessment. R3's record lacked an initial RN assessment completed prior to the initiation of services. On October 24, 2022, at 3:58 p.m., LALD/RN-A, provided a pre-admission RN assessment for R3, dated October 24, 2022. LALD/RN-A stated R3's assessment was done, but not submitted in the electronic record until today (October 24, 2022). On October 26, 2022, at 9:50 a.m., R3 stated there had not been nursing assessments done with him. On October 26, 2022, at 12:47 p.m., LALD/RN-A stated she completed an initial assessment for R3 June 7, 2022, and documented it on paper. The assessment was not provided. LALD/RN-A further stated no additional assessments had been documented in the electronic record system prior to the survey. LALD/RN-A indicated she was the only nurse at the time and was looking to get more help to make sure documentation was completed. The licensee's Assessment Schedules policy	01610		

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01610	Continued From page 57 dated August 1, 2021, indicated and initial resident nursing assessment would be completed, "Prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, whichever is earlier." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 58 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 resident monitoring and reassessment, utilizing a uniform assessment tool, not to exceed 14 days after admission and , for two of two residents (R1, R3). Further the licensee failed to ensure the RN conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, not to exceed 90 calendar days from the last assessment date, 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 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 R1received services including assistance with medication administration, meals, housekeeping and laundry. R1's record lacked a RN reassessment completed within 14 days after start of services. On October 24, 2022, at 2:40 p.m., R1 stated an assessment with a RN had not occurred since her admission to the facility. On October 25, 2022, at 9:04 a.m., LALD/RN-A	01620		

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01620	Continued From page 59 stated R1 was transferred from one of their other facilities and was not aware new RN assessments were required. R3 R3 received services including assistance with activities of daily living (ADLs), medication administration, meal assistance, housekeeping and laundry. R3's record included an undated document titled Admission Assessment. The document included a medication list, but lacked documentation of a nursing assessment. R3's record lacked a RN assessment completed within 14 days after start of services. R3's record further lacked a completed RN assessment which had not exceeded 90 days from the last assessment date. On October 24, 2022, at 3:58 p.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, provided a pre-admission RN assessment for R3, dated October 24, 2022. LALD/RN-A stated R3's assessment was done, but not submitted in the electronic record until today (October 24, 2022). On October 26, 2022, at 9:50 a.m., R3 stated there had not been nursing assessments done with him since his admission to the facility. On October 26, 2022, at 12:47 p.m., LALD/RN-A stated she completed an initial assessment for R3 June 7, 2022, and documented it on paper. The assessment was not provided. LALD/RN-A further stated no additional assessments had been documented in the electronic record system prior to the survey. LALD/RN-A indicated she was the only nurse at the time and was looking to get more help to make sure documentation was	01620		

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01620	Continued From page 60 completed. The licensee's Assessment Schedules policy, dated August 1, 2021, indicated resident reassessments would be completed, "no more than 14 calendar days after the initiation of services," and, "as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (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.	01640		

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01640	Continued From page 61 (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 finalize a current written service plan within 14 calendar days for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 had diagnoses including intellectual development disability, anxiety and panic attacks. R1's record indicated R1 received services including assistance with medication management, meals, housekeeping and laundry. R1's record lacked a signed service plan with the required content, developed prior to the initiation of services. On October 24, 2022, at 2:40 p.m., R1 stated she did not remember if she signed a service plan, but did feel she was getting the services she needed. On October 25, 2022, at 11:46, a.m., the licensed	01640		

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01640	Continued From page 62 assisted living director, who was also the registered nurse (LALD/RN)-A stated she was unable to locate a service plan for R1. R3 R3 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R3's record indicated R1 received services including assistance with medication management, activities of daily living (ADLs), meals, housekeeping and laundry. R3's record lacked a signed service plan with the required content, developed prior to the initiation of services. On October 26, 2022, during a 9:50 a.m. interview, R3 stated he had not signed anything, including a service plan. R3 further stated that was why the surveyors were unable to find it. On October 26, 2022, at 1:23 p.m., LALD/RN-A provided an unsigned assisted living contract for R3, dated June 7, 2022. The contract included service plan information on pages 42-48, but the plan did not indicate it was R3's service plan and included information not relevant to R3. -LALD/RN-A stated she was unable to provide the service plan because she could not access it in the electronic record system. LALD/RN-A further stated the service plan was not yet signed because it was part of the contract and R3's case manager wanted to see it before it was signed. The licensee's Service Plan policy dated August 1, 2021, indicated "All residents receiving assisted living services will have a service plan in place." The policy further indicated, "The service plan and any revisions shall include a signature or	01640		

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01640	Continued From page 63 other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided." The policy further indicated the service plan would include: a. A description of the services to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will provide services (RN, LPN, unlicensed personnel, etc.); e. A schedule and method for the next planned assessment or monitoring; f. A schedule and method for the next planned monitoring of staff providing services; and g. A contingency plan that includes: i. Actions [licensee] will take if scheduled services cannot be provided ii. Information regarding how the resident can contact [licensee] iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01700 SS=E	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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for two of two residents (R1, R3).	01700		

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01700	Continued From page 65 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 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 and R3's records lacked a completed RN medication management assessment prior to the start of medication management services. R1 R1 received services including assistance with medication administration, meals, housekeeping and laundry. R1's record lacked evidence the RN, who was also the licensed assisted living director (LALD/RN)-A, conducted a medication management assessment including: -have a RN, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided; -assessment must be conducted face-to-face; -assessment must include an identification and review of all medications the resident is known to be taking; and -review and identification must include indication, side effects, contraindications, allergies, adverse reactions and actions to address these issues. -the assessment must identify interventions needed in management of medications to prevent diversion of medications by resident or others	01700		

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01700	Continued From page 66 who 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. On October 24, 2022, at 2:40 p.m., R1 stated an assessment with a RN had not occurred on admission. On October 25, 2022, at 9:04 a.m., LALD/RN-A stated R1 had transferred from one of their other facilities and was not aware a new medication management assessment was required. R3 R3 received services including assistance with activities of daily living (ADLs), medication administration, meal assistance, housekeeping and laundry. On October 25, 2022, at 1:57 p.m., unlicensed personnel (ULP)-C was observed administering medications to R3. R3's record included an undated document titled Admission Assessment. The document included a medication list, but lacked documentation of a complete medication assessment. R3's record lacked evidence LALD/RN-A, conducted a medication management assessment including: -have a RN, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided; -assessment must be conducted face-to-face; -assessment must include an identification and	01700		

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01700	Continued From page 67 review of all medications the resident is known to be taking; and -review and identification must include indication, side effects, contraindications, allergies, adverse reactions and actions to address these issues. -the assessment must identify interventions needed in management of medications to prevent diversion of medications by resident or others who 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. On October 26, 2022, at 9:50 a.m., R3 stated there had not been any nursing assessments completed for him. On October 26, 2022, at 12:47 p.m., LALD/RN-A stated she completed an initial assessment for R3 June 7, 2022, and documented it on paper. The assessment was not provided. LALD/RN-A further stated no additional assessments had been documented in the electronic record system prior to the survey. LALD/RN-A indicated she was the only nurse at the time and was looking to get more help to make sure documentation was completed. The licensee's Medication Management - Assessment, Monitoring, and Reassessment policy dated August 1, 2021, indicated: -"prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided; -assessment must be conducted face-to-face with the resident by an RN.	01700		

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01700	Continued From page 68 -assessment must include an identification and review of all medications the resident is known to be taking. -review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. -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 (diversion of medication" means misuse, theft, or illegal or improper disposition of medications.); and -[licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 69 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required	01730		

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01730	Continued From page 70 content for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 R1had diagnoses including intellectual development disability, anxiety and panic attacks. R1's record indicated R1 received services including assistance with medication management. R1's record lacked a current medication management plan, completed prior to initiation of services, including the following: -a statement describing the medication management services that will be provided; -a description of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when	01730		

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01730	Continued From page 71 a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 24, 2022, at 2:40 p.m., R1 stated an assessment with a RN had not occurred on admission. On October 25, 2022, at 9:04 a.m., LALD/RN-A stated R1 was transferred from one of their other facilities and was not aware a new RN assessments, which would include a medication management record, were required. On October 25, 2022, at 11:46 a.m., LALD/RN-A provided a RN admission assessment which included an incomplete medication management plan for R1 dated October 25, 2022, created during survey. R3 R3 was admitted on June 7, 2022, and had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R3's record indicated R3 received services including assistance with medication management. On October 25, 2022, at 1:57 p.m., unlicensed personnel (ULP)-C was observed administering medications to R3. R3's undated medication management plan lacked the following:	01730		

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01730	Continued From page 72 -a description of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 24, 2022, at 3:58 p.m., LALD/RN-A, provided a pre-admission RN assessment which included an incomplete medication management plan for R3 dated October 24, 2022, created during survey. On October 26, 2022, at 12:47 p.m., LALD/RN-A indicated she was looking to get more help to make sure documentation was completed. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated, "[Licensee]will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: -a statement describing the medication management services that will be provided -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 73 directions -documentation of specific resident instructions relating to the administration of medications -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -identification of medication management tasks that may be delegated to unlicensed personnel -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 74 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure accurate documentation of medication administration 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 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 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R3's record indicated R3 received services including assistance with activities of daily living (ADLs), medication management, meal assistance, housekeeping and laundry. On October 25, 2022, at 1:57 p.m., unlicensed personnel (ULP)-C was observed administering medications to R3. R3's undated medication management plan indicated R3 needed total assistance with medication administration. R3's medication administration record (MAR) from October 2022 indicated R3 was scheduled to receive tamsulosin (a urinary health	01760		

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01760	Continued From page 75 medication) 0.4 milligram (mg) capsule by mouth daily. R3's MAR lacked documentation to indicate R3 received or refused the medication during the month of October. R3's MAR for October 1-24, 2022, indicated R3 was scheduled to receive quetiapine (seroquel-an anti-anxiety medication), "125 mg by mouth three times a day. Give 25 mg and 100 mg tablet." -R3's MAR indicated R3 was administered quetiapine 125 mg once per day at 2:00 p.m., October 1-9 and 12-24, 2022. The MAR further indicated R3 refused to take the medication October 10, 2022, and lacked documentation for October 11, 2022. R3's record included signed orders, dated July 13, 2022, indicating, "tamsulosin 0.4 mg by mouth daily". The signed orders further indicated, "seroquel [quetiapine] 100 mg by mouth three times daily," which was a different dosage than shown on R3's MAR. On November 2, 2022, during a 2:40 p.m. interview, the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated R3 was administered tamsulosin daily, and stated the medication was delivered from the pharmacy. LALD/RN-A stated the documentation was not completed because she had incorrectly marked the medication as "self-administer" in the electronic documentation system. -at 3:14 p.m., LALD/RN-A stated quetiapine was administered to R3 three times daily and verified the dosage delivered from the pharmacy was 100 mg, as indicated on the signed order. LALD/RN-A further stated entering information into the electronic documentation system had been a challenge for her, and she was still learning that process. LALD/RN-A stated staff would be	01760		

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01760	Continued From page 76 expected to follow the medication administration process to identify and notify the RN of any differences between the MAR and the medications administered. On November 4, 2022, at 4:08 p.m., a representative of the licensee's providing pharmacy, pharmacist (P)-E, verified the pharmacy delivered, for R3, tamsulosin 0.4 mg to be taken once daily, and quetiapine 100 mg three times daily, as indicated on R3's signed orders. The licensee's Medication and Treatment Record - Documentation & Refusal policy, dated August 1, 2021, indicated, "[Licensee] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies." The policy further indicated, "The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy." The policy further indicated, "If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided." No further information provided	01760		

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01760	Continued From page 77 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one 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) 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's diagnosis included intellectual development disability, anxiety and panic attacks R1's record indicated R1 received services for medication management, meals, housekeeping and laundry. R1s records lacked signed provider orders for the following medications:	01820		

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01820	Continued From page 78 -atorvastatin 20 milligram (mg) tablet, take one tablet PO daily at 8:00 a.m.; -sertraline 100 mg tablet, take one tablet PO daily in the morning; -hydrocodone/acetaminophen (dose undefined), take one tablet PO every six hours as needed (PRN) for pain; -ibuprofen (dose undefined), take one tablet PO every six hours PRN for dental pain; and -moderna COVID-19 Vaccine, pharmacist done injection into the muscle daily. On October 25, 2022, at 11:46 a.m., licensed assisted living director, who is also the registered nurse (LALD/RN)-A, stated she did not have signed medication orders for R1. On October 25, 2022, at 12:30 p.m., LALD/RN-A states she searched and had been unable to find signed medications orders for R1. On October 26, 2022, at 10:14 a.m., administrator (A)-B stated they were still trying to get signed medication orders for R1. A-B stated they made a request from the pharmacy for the medication orders. A-B stated the medication orders usually were not sent to the facility and would have to make a request for them. A-B stated they had no orders for R1 onsite at the time of survey. On October 26, 2022, at 10:59 a.m., LALD/RN-A was on the phone with the pharmacy asking them to send over prescriptions for R1. LALD/RN-A stated the pharmacy would not send her signed orders or sign them themselves. The licensee's Medication an Treatment Orders - Renewal policy, dated August 1, 2021, indicated, "Residents who receive medication management	01820		

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01820	Continued From page 79 services by [licensee] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 and interview, the licensee failed to ensure medications were stored under proper temperature controls according to manufacturer instructions. This had the potential to affect one of one (1) resident (R3) with refrigerated medications. Further, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and only authorized personnel had access. This had the potential to effect all four residents in 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01880		

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01880	Continued From page 80 or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION REFRIGERATOR On October 25, 2022, at 2:00 p.m., the medication refrigerator located in the office area was observed to lack a thermometer and daily log to monitor the temperature inside the refrigerator. The refrigerator contained a 500 milliliter (ml) bottle of gentamicin (an antibiotic) for bladder irrigation. The bottle included a label that indicated, "keep frozen/discard after 14 days refrigerated". There was no date on the bottle to indicate the date thawed or placed into the refrigerator. On October 25, 2022, at approximately 2:00 p.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated they did not have a thermometer in the medication refrigerator. LALD/RN-A stated she knew they should have one, but was not sure where it went. LALD/RN-A stated they did keep a temperature log, but would have to ask staff where it was. The log was not provided. LALD/RN-A stated they used the gentamicin irrigation daily, so they knew it would not last over 14 days. On October 25, 2022, at 2:15 p.m., the surveyor observed a partially frozen bottle of the gentamicin irrigation in door of the kitchen refrigerator where food was also stored. The refrigerator was unlocked. The bottle included a label indicating "keep frozen/discard after 14 days refrigerated". There was no date on the bottle to indicate when the bottle was placed in the refrigerator to thaw.	01880		

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01880	Continued From page 81 On October 25, 2022, at 2:42 p.m., ULP-D stated she administered the gentamicin bladder irrigation for R3 when she worked the evening shift. ULP-D further stated she had taken a bottle from the freezer and stored it in the refrigerator, but had not put a date on it because it was used quickly. ULP-D further stated the bottle was stored in the kitchen refrigerator because staff did not always have access to the medication refrigerator in the office in the evening. MEDICATION STORAGE CABINETS AND NARCOTIC LOCK BOX On October 25, 2022, at 2:10 p.m., the medication cabinets were observed with ULP-C. ULP-C retrieved the medication cabinet keys and key fob from a yellow bucket approximately 4-5 feet (ft) away from the medication cabinets. ULP-C stated the keys were kept in the yellow bucket most of the time. There were two medication cabinets, the second/left medication cabinet was unlocked and contained the narcotic lock box. On October 25, 2022, at 2:34 p.m., surveyor requested access to the narcotic lock box stored in the second/left medication cabinet. LALD/RN-A and ULP-C both stated they did not know where the narcotic lock box key was. LALD/RN-A stated the narcotic lock box key should have been on the same key ring as the medication cabinet keys. LALD/RN-A stated to ULP-C they could try the key for R1's bedroom cabinet which was similar in shape and design (round and hollow) to gain access to the narcotic lock box. ULP-C stated to LALD/RN-A the key was not the same and would not work.	01880		

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01880	Continued From page 82 On October 25, 2022, at 2:36 p.m., LALD/RN-A stated the keys for the medication cabinets were always kept in the yellow bucket. LALD/RN-A stated the residents would never take the keys to access the medication cabinets. On October 26, 2022, at 9:43 a.m., the medication cabinets were observed with ULP-D. ULP-D retrieved the medication cabinet keys and key fob from a yellow bucket approximately 4-5 ft away from the medication cabinets. ULP-D stated the keys were always kept in the yellow bucket. ULP-D stated the administrator (A)-B gave them the narcotic lock box key and the other one had been lost. On October 26, 2022, at 10:14 a.m., LALD/RN-A stated she knew the medication cabinet keys should not be kept out in the open. The licensee's Medication Storage policy, dated July 30, 2021, indicated, "When medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 83 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including labeling with resident information, storing medication in its original packaging and labeling with an opened-on date. This had to potential to affect all four residents at 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) 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 August 22, 2022, and had diagnoses including intellectual development disability, anxiety and panic attacks R1's record indicated R1 received services including assistance with medication management. OBSERVATIONS On October 25, 2022, at 2:10 p.m., the unlocked second/left medication cabinet was observed with unlicensed personnel (ULP)-C and contained a transparent orangish-brown Walgreen's medication bottle, approximately 4 inches (in.) tall and 2 in. wide. The bottle was labeled, "Equate,	01890		

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	35520	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

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01890	Continued From page 84 Acetaminophen 500 milligrams (mg)," written by hand with a black magic marker. The medication bottle was approximately three-quarters full of white oblong tablets with L484 engraved into them (L484 is a pill identification number and identified the pills as acetaminophen). On October 25, 2022, at 2:10 p.m., the unlocked second/left medication cabinet was observed with ULP-C and contained an opened pink and white medication bottle, approximately 2 in. by 1 in., labeled Equaline Allergy Relief. The medication bottle indicated 100 diphenhydramine 25 mg tablets were in the bottle with a May, 2023, expiration date. The tablets were oblong and pink in color. The bottle was not labeled with an opened-on date or resident identifying information. On October 25, 2022, at 2:10 p.m., the unlocked second/left medication cabinet was observed with ULP-C and contained a pink and white box labeled Equate Allergy Relief. The box indicated it contained 24 soft gel capsules of diphenhydramine HCL 25 mg. 19 soft yellow gel capsules remained in bubble punch cards in the box with a February, 2023, expiration date. The box was not labeled with an opened-on date or resident identifying information. On October 25, 2022, at 2:10 p.m., the unlocked second/left medication cabinet was observed with ULP-C and contained a blue jar, approximately 2.5 in. by 2 in. of vaporizing chest rub which was opened and three-quarters full, indicating an August, 2021, expiration date. On October 26, 2022, at 9:43 a.m., the Walgreen's Equate Acetaminophen 500 mg bottle, labeled with a black magic marker, was no	01890		

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01890	Continued From page 85 longer in the second/left medication cabinet. On October 26, 2022, at 9:46 a.m., black Deterra drug deactivation system medication disposal bags were observed in a plastic 4 drawer cabinet approximately 4 feet from both the first/right and second/left medicine cabinets. On October 26, 2022, at 10:50 a.m., the first/right medicine cabinet was observed with ULP-C which contained a bottle of eye drops found at the bottom of R1's medication storage basket. The purple and white box contained a 0.5 fluid (fl) ounce (oz) or 15 milliliters (ml)) Opcon-A eye allergy drops in a sandwich sized plastic baggy. The box and bottle had been opened. Neither the box or bottle were labeled with an opened-on date or label with resident identifying information. The expiration date was unreadable. The Opcon-A eye allergy drops were not found on R1's medication administration record (MAR). INTERVIEWS On October 25, 2022, at 2:10 p.m., ULP-C stated the Walgreen's Equate Acetaminophen 500 mg bottle labeled with a black magic marker in the second/left cabinet belonged to the licensed assisted living director, who was also the registered nurse (LALD/RN)-A, but was unsure who the other medications belonged to. On October 25, 2022, at 2:10 a.m., ULP-C stated it was the LALD/RN-A's job to go through the medication cabinets and check for expired medications. ULP-C stated the ULP's did not do any of the disposal of medications. On October 25, 2022, at 2:36 p.m., LALD/RN-A stated all medications, identified above in the	01890		

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01890	Continued From page 86	01890		

second/left medicine cabinet, were expired and waiting to be disposed of. LALD/RN-A stated she was still waiting for a company to provide disposal bags so she could destroy them. LALD/RN-A would not provide an explanation as to why they were unlabeled, how long they had been there and which resident they belonged to.

On October 26, 2022, at 9:43 a.m., ULP-D stated it was the LALD/RN-A's job to go through the medication cabinets and checked for expired medications.

On October 26, 2022, at 9:48 a.m., LALD/RN-A stated she did not know why there were Opcon-A eye allergy drops in R1's medication basket. LALD/RN-A stated the acetaminophen had been destroyed yesterday on October 25, 2022. LALD/RN-A would not provide an explanation as to why the Equate Allergy Relief, Equaline Allergy Relief, and vaporizing chest rub remained undestroyed in the second/left medication cabinet.

On October 26, 2022, at 10:50 a.m., ULP-C stated R1 was not being given the Opcon-A eye allergy drops. ULP-C stated she had never administered R1 the Opcon-A eye allergy drops. ULP-C stated the drops may have come from her previous facility when she transferred in August, 2022.

On October 26, 2022, at 11:30 a.m., LALD/RN-A stated she was unaware the Opcon-A eye allergy drops were in R1's medication basket and stated it was not on R1's medication list. LALD/RN-A would not identify whose responsibility it was to monitor and audit the medication cabinets to check for expired medications, how often the medication cabinets was checked and how often

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01890	Continued From page 87 resident MAR's and prescriptions were reviewed. Licensee's Clinical Nurse Supervisor position description dated June, 2021, indicated it was the responsibility of the RN to conduct, "Reviews each client's medication sheet at least monthly and assures accuracy and appropriate signatures." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

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01910	Continued From page 88 by: Based on interview, observation and record review, the licensee failed to dispose of medications and provide documentation for undisposed medication. This had the potential to affect all four residents at 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) 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 had diagnoses including intellectual development disability, anxiety and panic attacks. R1's record indicated R1 received services including assistance with medication management. OBSERVATIONS On October 25, 2022, at 2:10 p.m., the unlocked second/left medicine cabinet was observed with unlicensed personnel (ULP)-C which contained a transparent orangish-brown Walgreen's medication bottle, approximately 4 inches (in.) tall and 2 in. wide. It had no sticker, label or resident identifying information. "Equate, Acetaminophen 500 milligrams (mg)," had been written on the bottle with a black magic marker. The medication bottle was approximately three-quarters full with white oblong tablets with L484 engraved into them (L484 is a pill identification number and identified the pills as acetaminophen).	01910		

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01910	Continued From page 89 On October 25, 2022, at 2:10 p.m., the unlocked second/left medicine cabinet was observed with ULP-C and contained an opened pink and white medication bottle, approximately 2 in. by 1 in., labeled Equaline Allergy Relief. The medication bottle indicated 100 diphenhydramine 25 mg tablets were in the bottle, expiration dated May, 2023. The tablets were oblong and pink in color. The bottle was not labeled without an opened-on date or resident identifying information. On October 25, 2022, at 2:10 p.m., the unlocked second/left medicine cabinet was observed with ULP-C and contained a pink and white box labeled Equate Allergy Relief. The box indicated it contained 24 soft gel capsules of diphenhydramine HCL 25 mg. 19 yellow soft gel capsules remained in bubble punch cards in the box, expiration dated February, 2023. The box was not labeled with an opened-on date or resident identifying information. On October 25, 2022, at 2:10 p.m., the unlocked second/left medicine cabinet was observed with ULP-C and contained a blue jar, approximately 2.5 in. by 2 in. of vaporizing chest rub which was opened and three-quarters full, expiration dated August, 2021. On October 26, 2022, at 9:43 a.m., the Walgreen's equate acetaminophen 500 mg bottle, labeled with a black magic marker, was observed to no longer be in the second/left medication cabinet. On October 26, 2022, at 9:46 a.m., black Deterra drug deactivation system medication disposal bags were observed in a plastic 4 drawer cabinet approximately 4 feet from both the first/right and second/left medicine cabinets.	01910		

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01910	Continued From page 90 On October 26, 2022, at 10:50 a.m., the first/right medicine cabinet was observed with ULP-C which contained a bottle of eye drops found at the bottom of R1's medication storage basket. The purple and white box contained a 0.5 fluid (fl) ounces (oz) 15 milliliters (ml)) Opcon-A eye allergy drops in a sandwich sized plastic baggy. The bottle had been opened. Neither the box or bottle were labeled with an opened-on date or label which identified it as R1's medication. The expiration date was unreadable. The Opcon-A eye allergy drops were not on R1's medication administration record (MAR). INTERVIEWS On October 25, 2022, at 2:10 a.m., ULP-C stated the ULP's were not the ones to dispose of medications. On October 25, 2022, at 2:36 p.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated, all medications identified above in the second/left medicine cabinet, were expired and waiting to be disposed. LALD/RN-A stated she was still waiting for a company to provide disposal bags so she could destroy them. LALD/RN-A would not provide an explanation as to why they were unlabeled, how long they had been there and which resident they belonged to. LALD/RN-A stated she had no disposal documentation records for the medications found in the second/left. On October 26, 2022, at 9:42 a.m., ULP-D stated it was the LALD/RN-A's job to dispose of medications.	01910		

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01910	Continued From page 91 On October 26, 2022, at 9:48 a.m., LALD/RN-A stated the acetaminophen had been destroyed yesterday on October 25, 2022. LALD/RN-A would not provide an explanation as to why the remaining Equate Allergy Relief, Equaline Allergy Relief, and vaporizing chest rub remained undestroyed and in the second/left medication cabinet. Licensee's Medication Disposal policy dated August 1, 2021, indicated, "Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information provided. Time period for correction: Twenty-one (21) days	01910		
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 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	01940		

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01940	Continued From page 92 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 (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 had diagnoses including cerebral palsy,	01940		

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01940	Continued From page 93	01940		

depression, mood disorder and anxiety. R3's record indicated R3 received services including assistance with medication management, activities of daily living (ADLs), meals, housekeeping and laundry.

On October 25, 2022, at 9:25 a.m., unlicensed personnel (ULP)-C was observed to perform a urinary catheterization (a procedure to empty the bladder) to assist R3 to empty his bladder.

On October 25, 2022, at 2:00 p.m., the medication refrigerator located in the office area was observed to contain a 500 milliliter(ml) bottle of gentamcin (an antibiotic) irrigation solution. The bottle included a label that indicated it was for R3 with the instructions, "instill 60 ml in bladder at bedtime".

R3's record lacked a signed service plan indicating R3 received assistance with urinary catheterization and gentamicin bladder irrigation, developed prior to the initiation of services.

R3's record lacked a treatment or therapy management plan developed prior to the initiation of treatment services.

On October 26, 2022, at 10:30 a.m., ULP-C stated LALD/RN-A provided the training on urinary catheterization and gentamicin bladder irrigation, but there were no instructions documented in R3's record. ULP-C further stated the treatments have been done since R3 was admitted in June 2022.

On October 26, 2022, at 12:55 p.m., LALD/RN-A stated there were orders for the urinary catheterization and gentamicin bladder irrigation procedures for R3. LALD/RN-A further stated the

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01940	Continued From page 94 orders probably came from the hospital, and indicated she had a lot of orders to look through. The orders were not provided. The licensee's Treatment and Therapy Management Plan policy, dated August 1, 2021, indicated, "For each resident at [licensee] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." The policy further indicated, "[Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided; b. Documentation of specific resident instructions relating to the treatments or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; e. Any resident-specific requirements relating to documentation of treatment and therapy received; f. Verification that all treatment and therapy was administered as prescribed; and g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		

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01950	Continued From page 95	01950		
01950 SS=G	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) instructed and ensured competency of the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of one resident (R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01950		

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01950	Continued From page 96 or a violation that has the potential to lead to 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: R3 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R3's record indicated R1 received services including assistance with medication management, activities of daily living (ADLs), meals, housekeeping and laundry. On October 25, 2022, at 9:25 a.m., unlicensed personnel (ULP)-C was observed to perform a urinary catheterization (a procedure to empty the bladder) to assist R3 to empty his bladder. On October 25, 2022, at 2:00 p.m., the medication refrigerator located in the office area was observed to contain a 500 milliliter(ml) bottle of gentamcin (an antibiotic) irrigation solution. The bottle included a label that indicated it was for R3 with the instructions, "instill 60 ml in bladder at bedtime". R3's record lacked a signed service plan indicating R3 received assistance with urinary catheterization and gentamicin bladder irrigation, developed prior to the initiation of services. R3's record lacked a treatment or therapy management plan developed prior to the initiation of treatment services. On October 25, 2022, at 2:25 p.m., ULP-C stated	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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
01950	Continued From page 97 she performed the gentamicin irrigation daily at bedtime for R3. ULP-C further stated she did not document the treatment anywhere in R3's record. -LALD/RN-A stated she was not sure why the gentamicin bladder irrigation was not included in the documentation for R3. LALD/RN-A further stated she was trusting the medications delivered from the pharmacy were the correct medications. On October 26, 2022, during a 9:50 a.m. interview, R3 stated he was administered the gentamicin bladder irrigation every night before bed. On October 26, 2022, at 10:30 a.m., ULP-C stated LALD/RN-A provided the training on urinary catheterization and gentamicin bladder irrigation, but there were no instructions documented in R3's record. ULP-C further stated the treatments had been performed since R3 was admitted. ULP-C further stated, "we always do it, but did not document". On October 26, 2022, at 12:55 p.m., LALD/RN-A stated there were orders for the urinary catheterization and gentamicin bladder irrigation procedures for R3. LALD/RN-A further stated the orders "probably came from the hospital", and indicated she had a lot of orders to look through. The orders were not provided. On October 26, 2022, during a 12:56 p.m. interview, LALD/RN-A indicated that, during the survey, she had added the urinary catheterization and bladder irrigation documentation areas that were not previously present in R3's record. LALD/RN-A stated "I just added it to the charting, I just completed some that I missed." -LALD/RN-A further stated the documentation of ULP-D's training on urinary catheterization and	01950		

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01950	Continued From page 98 gentamicin bladder irrigation was completed on paper and was located somewhere in her files. The training documentation was not provided. The licensee's Medication and Treatment - Administration & Delegation policy, dated August 1, 2021, indicated, "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures; 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and 3. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered	01960		

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01960	Continued From page 99 and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (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 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 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. On October 25, 2022, at 9:25 a.m., unlicensed personnel (ULP)-C was observed to perform a urinary catheterization (a procedure to empty the bladder) to assist R3 to empty his bladder. On October 25, 2022, at 2:00 p.m., the medication refrigerator located in the office area was observed to contain a 500 milliliter(ml) bottle of gentamicin (an antibiotic) irrigation solution. The bottle included a label that indicated it was for R3, with the instructions, "instill 60 ml in bladder at bedtime". R3's record lacked a signed service plan indicating R3 received assistance with urinary catheterization and gentamicin bladder irrigation,	01960		

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01960	Continued From page 100 and a treatment or therapy management plan developed prior to the initiation of treatment services. R3's record lacked documentation of administration of the gentamicin bladder irrigation and urinary catheterization procedures. On October 25, 2022, at 2:25 p.m., ULP-C stated she performed the gentamicin bladder irrigation daily at bedtime for R3. ULP-C further stated she did not document the treatment anywhere in R3's record. -LALD/RN-A added she was not sure why the gentamicin bladder irrigation was not included in the documentation for R3. On October 26, 2022, at 10:30 a.m., ULP-C stated the treatments have been done since R3 was admitted. ULP-C further stated, "we always do it, but did not document". On October 26, 2022, during a 12:56 p.m. interview, LALD/RN-A indicated that, during the survey, she had added the urinary catheterization and bladder irrigation documentation areas that were not previously present in R3's record. LALD/RN-A stated "I just added it to the charting, I just completed some that I missed." The licensee's Medication & Treatment Record - Documentation & Refusal policy, dated August 1, 2021, indicated, "[Licensee] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies." No further information was provided.	01960		

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01960	Continued From page 101 TIME PERIOD OF CORRECTION: Seven (7) days	01960		
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 obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (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 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 had diagnoses including cerebral palsy, depression, mood disorder and anxiety.	01970		

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01970	Continued From page 102 On October 25, 2022, at 9:25 a.m., unlicensed personnel (ULP)-C was observed to perform a urinary catheterization (a procedure to empty the bladder) to assist R3 to empty his bladder. On October 25, 2022, at 2:00 p.m., the medication refrigerator located in the office area was observed to contain a 500 milliliter(ml) bottle of gentamicin (an antibiotic) irrigation solution. The bottle included a label that indicated it was for R3, with the instructions, "instill 60 ml in bladder at bedtime". R3's record lacked signed prescriber orders for urinary catheterization and gentamicin bladder irrigation. On October 25, 2022, at 2:25 p.m., ULP-C stated staff performed the gentamicin irrigation daily at bedtime for R3. -LALD/RN-A stated she was trusting the medications delivered from the pharmacy were the correct medications. On October 26, 2022, at 10:30 a.m., ULP-C stated LALD/RN-A provided the training on urinary catheterization and gentamicin bladder irrigation, but there were no instructions documented in R3's record. ULP-C further stated the treatments had been done since R3 was admitted. ULP-C further stated, "we always do it, but did not document". On October 26, 2022, at 12:55 p.m., LALD/RN-A stated there were orders for the urinary catheterization and gentamicin bladder irrigation procedures for R3. LALD/RN-A further stated the orders probably came from the hospital, and indicated she had a lot of orders to look through. The orders were not provided.	01970		

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01970	Continued From page 103 The licensee's Medication & Treatment Orders policy, dated August 1, 2021, indicated, "All orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and memory care resident(s) receiving assisted living services.	02040		

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02040	Continued From page 104 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On October 27, 2022, from approximately 12:00 p.m., to 12:30 p.m., a documentation review and interview were performed with administrator (A)-B on the hazard vulnerability or safety risk assessment for the memory care physical environment. The review indicated the following: 1) No plan documentation was provided to indicate the licensee had performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. 2) Review of the plan documentation indicated the licensee did not identify mitigations to protect memory care residents from harm. Prevention measures or mitigations must be developed and documented in the plan to address all potential hazard vulnerabilities for this property. On October 27, 2022, at approximately 12:45 p.m., during the exit interview, A-B confirmed the above findings and requested for more information to develop a plan. No further information was provided.	02040		

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02040	Continued From page 105 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02090 SS=D	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a resident's dignity and privacy while providing assistance with cares 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's nursing assessment dated October 24, 2022, indicated R3 had diagnoses including cerebral palsy, depression and anxiety. The assessment further indicated R3 received total assistance with showers, and required a Hoyer lift (a mechanical lift used to assist in transfers) and assistance of two caregivers for transfers.	02090		

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02090	Continued From page 106 On October 25, 2022, at 9:06 a.m., unlicensed personnel (ULP)-C and ULP-D provided cares for R3 in R3's room. ULP-C and ULP-D placed a mechanical lift sling under R3 to transfer R3 out of bed for a shower. ULP-C operated the lift to raise R3 off the bed while ULP-D guided R3. With R3's body concealed, ULP-C and ULP-D wheeled R3 in the mechanical lift 48 feet down the hall in the common area of the home to the shower room, which was located approximately 15 feet from the kitchen area of the facility. Once in the shower room, the staff provided privacy and assisted R3 with a shower. On October 25, 2022, at approximately 9:30 a.m., ULP-C stated they used the lift to transport R3 to the shower room because they had no rolling shower chair. ULP-C further stated they had to "make do" with what they had. On October 25, 2022, at approximately 9:30 a.m., R3 stated he was fine with being wheeled to the shower room in the lift because, "I need my shower," and further stated, "we gotta do what we gotta do." On October 25, 2022, at 10:01 a.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A indicated R3 was transported in the mechanical lift down the hallway through the common area of the facility each time R3 had a shower. LALD/RN-A stated it was done, "because it is too hard to put [R3] in the chair and transfer that way." On October 26, 2022, during a 9:50 a.m. interview, R3 stated he would rather not get his shower by being transported down the hall in the lift, but was willing to do it, if necessary, to get a shower. R3 stated, "I kind of feel bad, [surveyor],	02090		

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02090	Continued From page 107 that you had to see that yesterday. It was embarrassing." R3 confirmed to the surveyor he was referring to being transported through the common area of the facility to the shower room in the hoyer lift. On October 26, 2022, at 10:30 a.m., ULP-C stated R3 had not told staff he was embarrassed to be transported down the hallway in the lift. ULP-C added R3 always seemed happy and in a good mood and they always ensured R3 was covered while being rolled in the lift. On October 26, 2022, at 12:56 p.m., LALD/RN-A stated she had considered R3's dignity in regards to transporting R3 through the common area of the facility in a mechanical lift. LALD/RN-A stated they ensured R3 was covered. LALD/RN-A indicated it was not a concern because R3 often preferred to be uncovered while in bed, and always preferred light clothing such as shorts while sitting in the living room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02090		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy	02110		

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02110	Continued From page 108 shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement the additional policies and procedures of an Assisted Living Facility with Dementia Care (ALFDC). This had the potential to affect all residents 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	02110		

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02110	Continued From page 109 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's policy binder lacked policies and procedures that address the following: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. R1 had diagnoses including intellectual development disability, anxiety and panic attacks.	02110		

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02110	Continued From page 110 R3 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R1 and R3's records lacked a signed assisted living contract and documentation they or their representative were provided the required policies and procedures related to ALFDC. On October 25, 2022, at 8:42 a.m., the surveyor requested to see the additional policies required for an ALFDC. The licensed assisted living director, who was also the registered nurse (LALD/RN)-A stated the policy binder did not include that section, but was not sure why. LALD/RN-A stated the dementia care policies should be provided along with resident contracts on admission. On October 25, 2022, at 9:04 a.m., LALD/RN-A stated since R1 was a transfer from one of their other facilities she was not aware a new contract would be required which would have included the dementia care policies. On October 26, 2022, at 1:23 p.m., LALD/RN-A stated R3's case manager wanted to review the assisted living contract before R3 signed it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

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02140	Continued From page 111 (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensed assisted living director, who was also the registered nurse (LALD/RN)-A was hired July 15, 2010, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living facility with dementia care (ALFDC). LALD/RN-A's employee record lacked documentation of completion of an approved dementia training program and knowledge/competency test. On October 25, 2022, at 8:36 a.m., ULP-D stated LALD/RN-A provided all staff training including dementia care training.	02140		

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02140	Continued From page 112 On October 25, 2022, at 3:07 p.m., LALD/RN-A stated she provided the dementia care training for staff. LALD/RN-A further stated she used videos, and also did research and developed the test questions for dementia care training. LALD/RN-A further stated she did not have documentation of her own dementia care training, but had much experience related to dementia in previous positions during 27 years of working as a RN. The licensee's Dementia Training policy, dated August 1, 2021, indicated, "All staff of [licensee] are required to complete dementia training at the time of hire and annually thereafter. The policy did not address qualification requirements of the staff that provided the training. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		
02240 SS=E	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240		

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02240	Continued From page 113 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" and "Minnesota Adult Abuse Reporting Center (MAARC)" was provided to the resident and a written acknowledgement received for two of two residents (R1, R3).	02240		

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02240	Continued From page 114 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 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 had diagnoses including intellectual development disability, anxiety and panic attacks. R3 had diagnoses including cerebral palsy, depression, mood disorder and anxiety. R1 and R3's records both lacked a signed contract, and documentation of receipt of the Assisted Living Bill of Rights and MAARC reporting information. On October 25, 2022, at 8:42 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated the Minnesota Assisted Living Bill of Rights, MAARC information, and acknowledgement of receipt should be provided along with resident contracts. On October 25, 2022, at 9:04 a.m., LALD/RN-A stated since R1 was a transfer from one of their other facilities she was not aware a new contract would be required which would have included the Minnesota Assisted Living Bill of Rights and MAARC reporting information and acknowledgement. On October 26, 2022, at 9:50 a.m., R3 stated he	02240		

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02240	Continued From page 115 had not signed a contract and had not seen the Minnesota Assisted Living Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content. 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:	02260		

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02260	Continued From page 116 On October 24, 2022, at 11:25 a.m., during the entrance conference the licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated the licensee was an assisted living facility licensed for dementia care. On October 25, 2022, at 8:42 a.m., LALD/RN-A stated she was unable to locate documents for dementia care training and policies to provide to residents and families. Licensee's Dementia Training policy dated August 1, 2021, indicated, "[Licensee] will provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards	02310		

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02310	Continued From page 117 regarding bed rails for two of two residents (R2, R3) with bed rails. This resulted in an immediate correction order on October 24, 2022, at 3:45 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 had diagnoses to include dwarfism, blindness, intellectual disability, and obesity. R2's record included an undated admission assessment. The assessment indicated R2 was at risk for falling. The assessment further indicated R2 used a bed placed on the floor and did not address the use of side rails. R2's record included a safety assessment last updated May 10, 2022. The assessment did not indicate R2 used side rails. R2's electronic record lacked any further documented assessments. R2's record lacked documentation of measurements of side rail entrapment zones, side rail assessment, and documentation of risk versus benefit assessment education provided regarding side rail safety.	02310		

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02310	Continued From page 118 On October 24, 2022, at 1:11 p.m., the surveyor observed R2 in his bedroom laying in bed. R2's bed was a hospital-style bed with identical half side rails in place on the upper half of both sides of the bed. The left side of the bed was positioned against the wall, and both side rails were firmly affixed. Unlicensed personnel (ULP)-C stated the side rails were kept in the up position at all times when R2 was in bed. On October 24, 2022, at 1:36 p.m., the licensed assisted living director, who was also the registered nurse (LALD/RN)-A was not aware she was required to document the side rail entrapment zones. RN-A further stated R2's side rails were installed by a medical supply company upon admission. RN-A measured R2's bed rail, which was found to be within the FDA recommended dimensional measurements for entrapment zones 1-4. Zone 1 was 3.25 inches ("), zone 2 was 0", zone 3 was 1.5", and zone 4 was 1.5". On October 24, 2022, at 1:45 p.m., LALD/RN-A stated R2's family did not like the bed and siderails, but LALD/RN-A verbalized to family the side rails would be for safety. LALD/RN-A indicated she gave verbal education to R2's family regarding side rail use but was not sure if there was documentation. R3 R3 had diagnoses to include cerebral palsy. R3's record included an undated admission assessment. The assessment did not address the use of side rails. R3's record included a safety assessment last updated May 10, 2022. The assessment did not	02310		

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02310	Continued From page 119 indicate R3 used side rails. R3's record lacked documentation of measurements of side rail entrapment zones, side rail assessment, and documentation of risk versus benefit assessment education provided regarding side rail safety. On October 24, 2022, at 1:06 p.m., the surveyor observed R3's bed was a hospital-style bed with identical ¾ length metal side rails on both sides of the bed. The side rails were observed currently in the down position, firmly affixed, and positioned in the center of the bed on both sides. ULP-C stated both side rails were kept in the up position at all times when R3 was in the bed. On October 24, 2022, at 1:45 p.m., LALD/RN-A measured R3's bed rails, which were found to be within the FDA recommended dimensional measurements for entrapment zones 1-4. Zone 1 was 4.25", zone 2 was 0", zone 3 was 0.5", and zone 4 was non-existent for the side rail style. On October 24, 2022, at 2:39 p.m., LALD/RN-A stated R3's bed and side rails were installed by a medical supply company upon admission. The surveyor asked LALD/RN-A if any education was documented regarding side rails for R3. LALD/RN-A stated she was not sure. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

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02310	Continued From page 120 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 (space between the rails), should be less than four and three quarters' inches. The licensee's siderails policy dated August 1, 2021, indicated, "When [licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." The policy further indicated when side rails were in use, an RN must conduct an assessment to identify the intended purpose and risks regarding the use of the side rail. The policy further indicated, "1. Staff from [licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This	02310		

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02310	Continued From page 121 means side rail zones 1, 2, and 3 must not exceed 4.75". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE At the time of exit on October 28, 2022, at 10:38 a.m., the immediacy of this order was not removed.	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services during use of a mechanical lift for one of one resident (R3). This resulted in an immediate order issued on October 25, 2022, at 12:42 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	02320		

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02320	Continued From page 122 portion or all of the residents). The findings include: R3 had diagnoses to include cerebral palsy. R3's record included a Planned Services list, printed October 24, 2022, that indicated R3 should be assisted with bathing every two days using a Hoyer lift (a mechanical lift used to assist in transfers) and assist of two caregivers. On October 25, 2022, at 9:06 a.m., unlicensed personnel (ULP)-C and ULP-D provided cares for R3 in R3's room. ULP-C and ULP-D placed a mechanical lift sling under R3 to transfer R3 out of bed for a shower. ULP-C positioned the lift over R3's bed, and ULP-C and ULP-D attached the sling straps to the lift. With lift legs in the closed position (lift legs should be open during use to prevent the lift from tipping), ULP-C operated the lift to raise R3 off the bed while ULP-D guided R3. With R3's body concealed, ULP-C and ULP-D wheeled R3 in the mechanical lift 48 feet down the hall to the shower room. The legs of the lift were observed to be in the closed position during the transport. At the door to the shower room, ULP-C and ULP-D maneuvered the lift up a corrugated metal ramp 31.5 inches long and approximately 32 inches wide, into the shower room. Once in the shower room, ULP-D lowered R3 down to rest in a portable shower chair, and, leaving the sling attached to the lift, assisted R3 with a shower. On October 25, 2022, at approximately 9:30 a.m., ULP-C stated they used the lift to transport R3 to the shower room because they had no rolling shower chair. ULP-C further stated they had to "make do" with what they had.	02320		

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02320	Continued From page 123 On October 25, 2022, at approximately 9:30 a.m., R3 stated he was fine with being wheeled to the shower room in the lift because, "I need my shower," and further stated, "we gotta do what we gotta do." On October 25, 2022, at 10:01 a.m., registered nurse (RN)-A, who is also the licensed assisted living director (LALD), stated they always transported R3 to the shower room using the lift "because it is too hard to put him in the chair and transfer that way." On October 26, 2022, during a 9:50 a.m. interview, R3 stated he would rather not get his shower by being transported down the hall in the lift, but was willing to do it, if necessary, to get a shower. R3 stated, "I kind of feel bad, [surveyor], that you had to see that yesterday. It was embarrassing." R3 confirmed to the surveyor he was referring to being transported through the common area of the facility to the shower room in the hoyer lift. On October 26, 2022, at 2:02 p.m., administrator (A)-D indicated they had a customized shower chair on order to use to give R3 his shower, but were not sure how long it would be until they received it. The Invacare user manual for the Reliant 450 model (the model used to transfer R3), copyright 2011, indicated, "The Invacare patient lift is NOT a transport device. It is intended to transfer an individual from one resting surface to another (such as a bed to a wheelchair)." The user manual further indicated, "When using an adjustable base lift, the legs MUST be in the maximum Opened/Locked position before lifting	02320		

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GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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
02320	Continued From page 124 the patient," and "During transfer, with patient suspended in a sling attached to the lift, DO NOT roll caster base over uneven surfaces that could cause the patient lift to tip over." The user manual further indicated, "If the bathroom facilities are NOT near the bed or if the patient lift cannot be easily maneuvered towards the commode, then the patient MUST be transferred to a wheelchair and transported to the bathroom facilities before using the patient lift again to position the patient on a standard commode." The user manual identified the base width of the lift as 26.5 inches with the legs in the closed position. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated, "A registered nurse or licensed health professional at [licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE At the time of exit on October 28, 2022, at 10:38 a.m., the immediacy of this order was not removed.	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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."	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35520	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT HOME MINNESOTA LLC	8668 ALVARADO COURT INVER GROVE HEIGHTS, MN 55077

(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
03090	Continued From page 125 (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 failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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: On October 24, 2022, at approximately 11:05 a.m., the surveyor entered the facility and observed the main entry door (on the back side of the home) and common areas, both lacked the required posting of electronic monitoring notice to visitors. On October 25, 2022, at 10:48 a.m., licensed assisted living director, who was also the registered nurse (LALD/RN)-A, stated they did not have cameras in the facility and therefore did not need the signage. LALD/RN-A stated she was aware of the requirements and had purchased signs from a store but had not yet put	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 126 them up. The licensee's Electronic Monitoring policy, dated August 1, 2021, indicated, "Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/24/22*
Time: 11:50:37
Report: 1036221071

Food and Beverage Establishment Inspection Report

Location:
Great Home Minnesota LLC - Alv
8668 Alvarado Court
Inver Grove Heights, MN55077
Dakota County, 19

Establishment Info:
ID #: 0036600
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Great Home Minnesota LLC

Phone #: 6519832005
ID #: 54450

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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH LOG EMAILED TO OPERATOR

Comply By: 10/28/22

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

NO HAND WASHING SINK PRESENT IN MAIN KITCHEN AREA. OPERATOR MUST DESIGNATE A SINK BASIN AS A HAND WASHING SINK TO BE USED FOR HAND WASHING ONLY. HANDWASHING SIGNAGE EMAILED TO OPERATOR.

Comply By: 10/28/22

2-100 Supervision

2-102.12AMN

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

NO CFPM EMPLOYED. HAVE AT LEAST ONE STAFF MEMBER TAKE 8 HOUR CLASS, PASS THE TEST, AND REGISTER WITH MDH. INSTRUCTIONS EMAILED TO OPERATOR.

Comply By: 10/28/22

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

WOOD CUTTING BOARD AND TONGS IN FOOD PREP AREA.

Comply By: 10/28/22

Surface and Equipment Sanitizers

Hot Water: = at >160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 40 Degrees Fahrenheit - Location: Whirlpool fridge-Kitchen
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: Amana fridge-Garage
Violation Issued: No

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

Announced inspection. Renee Anderson was the lead RN with HRD completing the site survey.

This is a residential house with kitchen equipment that is not ANSI certified. Food may be prepared for same day service only. There are currently 4 residents on site.

Discussed the following:
Employee illness policy and logging requirements
Glove-use
Handwashing procedure
No bare hand contact with ready to eat food
Thermometer use
Proper food storage
Sanitizing procedures for food contact surfaces
Fully cooking food for high risk populations
Violations on this report

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036221071 of 10/24/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

Graciela Aviles
Operator

Jeff Johanson