



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 22, 2025

Licensee
Comfort Care Homes
2521 12th Avenue South
Minneapolis, MN 55404

RE: License Number 416961
Health Facility Identification Number (HFID) 33632
Project Number(s) SL33632015

Dear Licensee:

On January 6, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 8, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 6, 2025.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 1, 2024

Licensee

Comfort Care Homes
2521 12th Avenue South
Minneapolis, MN 55404

RE: Conditional License Number 416961
Health Facility Identification Number (HFID) 33632
Project Number(s) SL33632015

Dear Licensee:

Please Note: This notice amends the Notice of Conditional License dated October 22, 2024. Specifically, a typo in the total openable area required for an egress window has been corrected to 648 (previously, the typo reflected 248) square inches (4.5 square feet). No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on August 22, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **January 20, 2025**.

STATE CORRECTION ORDERS

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Comfort Care Homes 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 survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Comfort Care Homes 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:** Comfort Care Homes will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Comfort Care Homes must provide the Department:
 - i. A list of the names and birthdates of any individuals Comfort Care Homes 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:** Comfort Care Homes will contract with an RN to provide consultation concerning all resident(s) to whom Comfort Care Homes provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Comfort Care Homes. 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 Comfort Care Homes and MDH must review the RN's credentials and approve the selection. Comfort Care Homes is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Comfort Care Homes in an effort to help Comfort Care Homes 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. Comfort Care Homes 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 Comfort Care Homes and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Casey.DeVries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

 - i. Progress towards correction of 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 Comfort Care Homes to correct the violations cited during the survey as well as to determine the overall practice of Comfort Care Homes 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. Health Facility Construction Permit:** Comfort Care Homes LLC will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Comfort Care Homes LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- g. General Contractor:** Comfort Care Homes LLC must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within two (2) weeks of the date of this notice:**

 - i. Name
 - ii. License Number
 - iii. Contact Information
- h. Egress Window Requirements: Comfort Care Homes LLC** will replace at least one window in resident bedroom 4, meeting the minimum size requirements.

 - i. Must have minimum openable width of no less than 20 inches.
 - ii. Must have minimum openable height of no less than 20 inches.
 - iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
 - v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.
- i. Follow-up survey:** At the time of the follow-up survey, 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.
- j. Corrective Action Plan:** Comfort Care Homes 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 EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Comfort Care Homes is in substantial compliance based on the results of the follow up

survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Comfort Care Homes is in substantial compliance on the follow up survey, MDH will remove the conditions from Comfort Care Homes's assisted living facility license, and Comfort Care Homes will correct any outstanding violations identified during the survey. If Comfort Care Homes is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH



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October 22, 2024

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RE: Conditional License Number 416961
Health Facility Identification Number (HFID) 33632
Project Number(s) SL33632015

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Sincerely,

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Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 12TH AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33632015-0 On August 19, 2024, through August 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents all of whom received services under the Assisted Living license. An immediate correction order was identified on August 20, 2024, issued for SL33632015-0, tag identification 0820. On August 21, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.		0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for		0 470		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2024
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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2024
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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of four residents. The licensee's undated Facility Staffing Plan indicated one direct care staff member was needed at the facility for the a.m. and p.m. shift seven days per week to meet the needs of the residents. The staffing plan lacked a written evaluation completed by the CNS twice per year. On August 19, 2024, at 11:37 a.m., CNS-C stated they reviewed the staffing plan when a resident's condition changed and updated the staffing plan as needed. CNS-C stated they did not have documentation to show when the staffing plan was reviewed or revised. The licensee's Staffing Plan policy dated August 1, 2022, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

Minnesota Department of Health

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0 480	Continued From page 3	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 12TH AVENUE SOUTH MINNEAPOLIS, MN 55404			
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0 550	Continued From page 4 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. 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: On August 19, 2024, at 11:45 a.m., during a facility tour, the surveyor observed the common	0 550			

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0 550	Continued From page 5 areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure. On August 19, 2024, at 12:05 p.m., clinical nurse supervisor (CNS)-C stated the facility was recently painted and they removed all the postings and did not put the postings back on the wall. CNS-C stated, "I am supposed to put it back it was overlooked." The licensee's Grievance policy dated August 1, 2022, indicated a copy of the grievance procedure was conspicuously posted in the facility with the following information: - name, phone number and email contact information for the individuals who are responsible for handling resident complaints; - contact information for the state and any regional Office of Ombudsman for Long-Term-Care; - contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630			

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0 630	Continued From page 6 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on April 29, 2020, under the licensee's previous comprehensive license, and began receiving assisted living services on August 1, 2021. R1's Service Plan (Waiver) - Addendum to Contract signed May 19, 2023, indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, incontinent care, laundry, behavior management, meals, medication administration, vital sign monitoring,	0 630			

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0 630	Continued From page 7 safety checks, shopping, and socialization. R1's IAPP dated February 16, 2024, indicated R1 was not at risk to abuse other vulnerable adults. R1's record lacked an individualized review or assessment of R1's susceptibility to be abused by another individual. R1's IAPP dated April 8, 2023, indicated R1 was not at risk to be abused. In addition, R1 behaviors included agitation towards others, withdrawal from reality and illogical thinking, and anxiety. R1's IAPP lacked an individualized review or assessment of the person's risk of abusing other vulnerable adults. On August 20, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated they were aware of the IAPP requirement however, they did not know they needed to address a person's risk to abuse others. The licensee's Vulnerable Adult policy dated August 1, 2022, read, "In compliance with Minnesota Statutes, all Comfort Care Homes employees are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640			

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0 640	Continued From page 8 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 (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 the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, at 12:47 p.m., the surveyor observed two landline black and silver mobile devices, one in the living room and one in the kitchen. The surveyor did not observe a posting of 911 emergency number in common areas and near telephones. The surveyor did observe a posting of the 911 emergency number on a	0 640			

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0 640	Continued From page 9 bulletin board above the dining room table. Clinical nurse supervisor (CNS)-C stated they did not know it was required to have a 911 emergency number posted near the telephones. In addition, CNS-C stated they did not post the 911 emergency number by the telephones to try to make the facility feel more home like. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services;	0 730			

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0 730	Continued From page 10 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document provided services for one of three residents (R1) in the resident's record as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 730			

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0 730	Continued From page 11 The findings include: R1 was admitted to the licensee and began receiving assisted living services on April 29, 2020. R1's service plan signed on May 19, 2023, indicated R1 received assistance with housekeeping, laundry, bathing, grooming, dressing, meals, medication set up, medication administration, behavior management, and toileting. R1's Service Recap Summary form August 1, 2024, through August 19, 2024, lacked the following documentation for services provided during multiple shifts: -4 of 36 scheduled services for dressing; -1 of 19 scheduled services for bathing; -1 of 19 scheduled services for grooming; -1 of 19 scheduled services for housekeeping; -3 of 19 scheduled services for incontinence care; -1 of 3 scheduled services for medication setup; -3 of 39 scheduled services for safety checks; -1 of 19 scheduled services for socialization; -2 of 19 scheduled services for medication administration; and -4 of 57 scheduled services for meal assistance. On August 19, 2024, at approximately 1:25 p.m., clinical nurse supervisor (CNS)- C stated R1 was on a leave of absence. CNS-C stated the ULPs were supposed to chart not given when residents did not receive a service. CNS-C stated the treatment administration record (TAR) was not supposed to be left blank. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 730			

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0 730	Continued From page 12 (21) days	0 730			
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 by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.	0 780			

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0 780	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C. Survey staff asked CNS-C to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. On August 20, 2024, at 1:00 p.m., CNS-C stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C. The following was observed. GENERAL MAINTENANCE: The window frame in bedroom 2 had water damage at the bottom of the frame adjacent to the sill on both sides. The wood was swollen and discolored. The light switch in bedroom 1 did not have a cover plate and was hanging out of the wall exposing the wiring and box to the room.	0 800			

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0 800	Continued From page 15 On August 20, 2024, at 1:00 p.m., CNS-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810			

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0 810	Continued From page 16 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024,from approximately 10:00 a.m. to 11:30 a.m., survey staff observed the fire evacuation diagrams showing the exit paths for the lower level and upper level of the facility were not posted anywhere in the facility. On August 20, 2024, clinical nurse supervisor (CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated July 19, 2022, failed to include the following:	0 810			

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0 810	Continued From page 17 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On August 20, 2024, at 1:00 p.m., CNS-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On August 20, 2024, at 1:00 p.m., CNS-C stated	0 810			

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0 810	Continued From page 18 they understood the requirements for training residents would implement a training program that was compliant with statute requirements. CNS-C stated they were planning to offer the training to residents at the new resident council meetings they were developing. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted on November 2, 2023, January 19, 2024, and March 18, 2024. No other documentation was provided. On August 20, 2024, at 1:00 p.m., CNS-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820			

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0 820	Continued From page 19 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 20, 2024, from approximately 10:00 a.m. to 11:00 a.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C. During the tour, survey staff asked CNS-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: One window measuring 16 inches clear width, 35 1/2 inches clear height, and 568 square inches total open area. The opening was obstructed by the windowpane due to how the crank hardware and arm moved the window. In the closed position the clear width measured 23 inches, but when opened the clear opening width was reduced significantly. Survey staff attempted	0 820	This immediate correction order identified on August 20, 2024, has had the immediacy lifted as of August 21, 2024, however non-compliance remained a scope and level of G.		

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0 820	Continued From page 20 to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. The window in bedroom 4 did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CNS-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On August 20, 2024, survey staff explained to CNS-C that an immediate correction order was issued for the above findings. CNS-C stated they understood the requirements for egress windows. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290			

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01290	Continued From page 21 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of six employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-A was hired on November 12, 2021, to provide direct cares and services to residents. ULP-A's employee record did not include a BGS clearance letter from the Department of Human Services (DHS). The licensee's NETstudy 2.0 (a web-based system for submitting background study requests to DHS) roster did not include ULP-A's BGS. The licensee's sister facility under HFID 34809	01290			

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01290	Continued From page 22 NETstudy 2.0 roster indicated ULP-A was eligible. The licensee lacked evidence ULP-A was affiliated to the licensee's HFID 33632 and was not included on the NETstudy 2.0 roster provided by the licensee. On August 20, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated ULP-A was originally hired for the sister facility and ULP-A ended up helping at the licensee's facility. CNS-C stated they forgot to affiliate ULP-A's BGS to the licensee's HFID. The licensee's undated Background Studies policy read, " Agency requires background screening to be completed on all final candidates for employment. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies are confidential and are retained in confidential employee files. Employees will not be able to start working with clients until the background check clearance has been received by the agency." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living 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	01610			

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01610	Continued From page 23 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for two of three residents (R2, R3) on or before the admission date. 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 was admitted to the facility on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder.	01610			

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01610	Continued From page 24 R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R2's record included admission assessment completed on August 18, 2024, and 14-day assessment also completed on August 18, 2024. On August 19, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-C stated they conducted the assessment on August 2, 2024, and forgot to complete both the admission and the 14-day assessments. CNS-C stated they reviewed the assessments on August 18, 2024, and found out it was not completed, and they completed both the admission assessment and the 14-day assessment on the same day, on August 18, 2024. R3 R3 was admitted to the facility on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R3's record included admission assessment completed on August 18, 2024. On August 19, 2024, at approximately 1:40 p.m., CNS-C stated they did do the assessment and	01610			

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01610	Continued From page 25 forgot to hit complete on the system. "It is same thing for [R3], I did it last night I just realized I did not hit complete last night". CNS-C stated it has been two years since they started using Rtasks (electronic medica record system software) and they were still learning the computer system. The licensee's Assessment and Reassessment Policy dated August 1, 2022, read, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery." No further 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	01620			

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01620	Continued From page 26 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a reassessment and monitoring no more than 14 calendar days after the initiation of services for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 was admitted to the facility on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder.	01620			

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01620	Continued From page 27 R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R2's record included admission assessment completed on August 18, 2024, and 14-day assessment also completed on August 18, 2024. R3 R3 was admitted to the facility on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R3's record included admission assessment completed on August 18, 2024. R3's record lacked 14-day assessment. On August 19, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-C stated they completed the assessment on August 2, 2024, and forgot to complete both the admission and the 14-day assessments. CNS-C stated they reviewed the assessments on August 18, 2024, and found out it was not completed, and they completed both the admission assessment and the 14-day assessment on the same day, on August 18, 2024. On August 19, 2024, at approximately 1:40 p.m.,	01620			

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01620	Continued From page 28 CNS-C stated they might have the 14-day assessment for R3 on paper at their main office. CNS-C also stated they were not hundred percent sure if they had done the assessment. CNS-C was unable to provide any documentation for R3's 14-day assessment. The licensee's Assessment and Reassessment Policy dated August 1, 2022, read, "The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01630 SS=E	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to initiate a temporary service plan for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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	01630			

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01630	Continued From page 29 pervasive). The findings include: R2 R2 admitted to the licensee and began receiving assisted living services on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder. R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R2's record lacked a temporary service plan not to exceed 72 hours. R2's service plan was finalized four days after their admission to the licensee. R3 R3 admitted to the licensee and began receiving assisted living services on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up, and record vital signs. R3's record lacked a temporary service plan not to exceed 72 hours. R3's service plan was finalized 14 days after their admission to the	01630			

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01630	Continued From page 30 licensee. On August 21, 2024, clinical nurse supervisor (CNS)-C stated they did not complete documentation for the above listed residents until the weekend of August 18, 2024. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640			

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01640	Continued From page 31 by: Based on observation, interview, and record review, the licensee failed to ensure the resident's service plan accurately reflected all services provided for three of three residents (R2, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R2 admitted to the licensee and began receiving assisted living services on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder. R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R2's admission assessment completed on August 18, 2024, 16 days after admission, indicated R2 needed full medication management and setup. The assessment also indicated R2 needed to be given medications at scheduled times and injectables as ordered. R2's Individualized Medication Management Plan	01640			

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01640	Continued From page 32 (IMMP) dated August 2, 2024, indicated R2 needed help with medication administration and needed to be given medications at scheduled times. R2's progress note dated August 14, 2024, indicated R2 received risperidone injection to R2's left deltoid. R2's Medication Administration Summary for the month of August 2024, indicated the licensee implemented the following medications for administration by the licensee's staff on August 19, 2024: - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - olanzapine 2.5mg, take 1 tablet daily; - prenatal plus 27-1mg, take 1 tab daily; - triamcinolone Acetonide 0.1%, apply a thin amount to affected area twice daily; - risperidone 1mg, take 1 tab twice daily; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; and - olanzapine (no dosage) take 1-2 tabs twice daily as needed (PRN) with doses 6 hours apart. On August 21, 2024, at approximately 9:50 a.m., clinical nurse supervisor (CNS)-C stated R2 had been getting their medication, but the medication administration service was not entered into the system until August 18, 2024. The surveyor inquired, who was administering the medication to R2. CNS-C stated themselves and the ULPs had been administering the medications. The surveyor inquired how ULPs would know what to administer, when to administer, and how the ULPs documented medication administration. CNS-C stated the five right rules were posted on the medication cabinet for the ULPs to refer to, and the resident's name, the name of the	01640			

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01640	Continued From page 33 medication, dosage and administration time were written on the medication labels. CNS-C also stated the ULPs were supposed to paper chart medication administration and stated they would check if they had the record of it. The surveyor inquired if the CNS had paper charted when they administered medications. CNS stated they should have paper charted medication administrations, but they had not. CNS-C did not provide any paper charting for R2's medication administration. R2's service plan indicated the licensee would provide R2 with medication set up by registered nurse (RN) one day a week, but lacked inclusion of medication administration services, which CNS-C stated staff and self had provided. R3 R3 admitted to the licensee and began receiving assisted living services on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R3's Admission Assessment completed on August 18, 2024, 26 days after admission, indicated R3 needed full medication management and setup. The assessment also indicated medication self-administration was not applicable for R3.	01640			

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01640	Continued From page 34 R3's Individualized Medication Management Plan (IMMP) dated August 19, 2024, indicated medication self-administration was not applicable and R3 needed reminders to take medications. R3's Medication Administration Summary for the month of August 2024, indicated the licensee implemented the following medications for administration by the licensee's staff on August 18, 2024: - aripiprazole 5 mg; - metformin 500 mg; and - olanzapine 10 mg. Also indicated was olanzapine 5 mg PRN (as necessary). On August 20, 2024, at 9:15 a.m., the surveyor observed R3's medication administration performed by unlicensed personnel (ULP)-B. ULP-B administered aripiprazole 5 mg and olanzapine 5 mg PRN (as needed), per R3's request. ULP-B also attempted to give Metformin 500 mg; R3 declined metformin and stated they get metformin at bedtime. On August 20, 2024, at 11:04 a.m., clinical nurse supervisor (CNS)-C stated R3 reported they were not taking any medication when they first got admitted to the licensee. CNS-C stated the pharmacy delivered R3's medication last Saturday (August 17, 2024) which prompted registered nurse (RN)-E to ask R3 to provide the medications they had been taking, then R3 provided the medications to RN-E. The surveyor inquired if they had reviewed R3's history and physical as part of their admission process to check what medications R3 was taking. CNS-C stated they did take verbal reports from the residents. Based on the verbal report from residents, if residents were on medications they	01640			

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01640	Continued From page 35 contacted the medical providers, if residents reported they were not taking medications, then the licensee did not contact the providers. The surveyor inquired; how did the pharmacy get the prescription orders to send the medications to the licensee. CNS-C stated they sent an in-take form to the pharmacy for all residents upon admission regardless of whether the resident was on medications or not. The pharmacy looked R3 up in their system and found out R3 had prescriptions for medications. On August 20, 2024, at 12:00 p.m., ULP-B provided the surveyor with handwritten progress notes and stated they were what RN-E used for R3's medication set up. - R3's progress note dated July 27, 2024, at 11:00 a.m., indicated RN-E "checked [R3's] medication. [R3] has been taking [their] own medication at bedtime. Will continue that for the present time." - R3's progress notes dated July 29, and August 4, 2024, indicated RN-E checked R3's medication supply, and noted R3 had adequate supply of all their medications, on both days. - R3's progress note dated August 17, 2024, indicated there were medication cards delivered that RN-E and R3 did not know about. RN-E indicated in their progress note that R3 stated they had seen numerous providers, and they did not remember what the medication were for. RN-E also indicated that they advised R3 to think of a provider that R3 would like to go to over the weekend and RN-E indicated that they would arrange appointment for R3. On August 20, 2024, at 12:56 p.m., the surveyor noted "medication set up by registered nurse (RN) one day a week" on the service plan and asked why medication setup was indicated on the service plan if R3 was not taking medications.	01640			

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01640	Continued From page 36 CNS-C stated they put medication set up services on the service plan in case the resident needed the service in the future they would offer it to residents. CNS-C also explained they knew R3 before admission and they knew R3 was on medications but R3 reported they did not have medication. CNS-C stated now they are aware that they were not supposed to put medication set up services on the service plan unless they are actively managing resident's medications. The surveyor viewed R3's Customized Living Rates Worksheet. On August 20, 2024, at 1:05 p.m., via email correspondence, the licensee provided the Department of Human Services Disability Service Division, Customized Living Rates Worksheet dated October 26, 2023, for the service period of July 23, 2024, through June 30, 2025; it indicated the following: - "Providing medication and water at the appropriate times. Doing medication charting on each time that [R3] is given a medication and fully documented to [R3's] MARs Folder. Scheduling the medications 2 or 3 times a day. On PRN Medications also given out to [R3] if she needs every 4, 6, or 12 hours as needed ordered by her provider or Nurse." - "The RN/Trained staff setting up medications 2 or 3 times a day and monitoring [R3's] response to medication, including new ordering or refill medication from her provider or ER doctors. Monitoring daily dose response directed by RN. The ULP Staff will continue monitoring [R3's] medication side affect [sic] as delegated by RN. [R3] currently is receiving Morning, & Bedtime medications and PRN medications as needed daily." R3's service plan inaccurately reflected the	01640			

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01640	Continued From page 37 services the licensee had assessed R3 needed and the services the licensee was expected to provide by DHS, despite CNS-C's assertion R3 was not taking medications at that time. However, CNS-C's statement R3 was not taking medications at the time of admission contradicted the information identified by RN-E in R3's progress notes. Further, R3's service plan was not revised and lacked inclusion of medication administration services when they began. R5 The licensee's Discharged Resident/ Client Roster dated January 1, 2024, to August 20, 2024, indicated R5 was admitted to the licensee on January 10, 2022, and discharged from the licensee on March 15, 2024. R5's diagnosis included schizophrenia, anxiety, nocturia, chemical dependency, suicidal ideations, and bipolar disorder. R5's Master Care Plan Agreement, dated April 8, 2023, indicated R5 needed full medication management. The care plan indicated "Nurse will be verifying and set-up medication. HHA [home health aide] will admin meds [administer medications] daily as scheduled/ordered." R5's most recent Individualized Medication Management Plan completed on January 18, 2023, indicated R5 received assistance with medication reminders by staff and medication set up by facility nurse. The plan indicated R5 was independent with medication administration. R5's Department of Human Services Disability Service Division, Customized Living Rates Worksheet dated December 8, 2023, indicated, "HHA [home health aide] does full medication	01640			

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01640	Continued From page 38 administration as ordered per day from preparing, handing it, and making sure that the client puts it to his mouth as scheduled and per orders. Staff administers, observes the client swallow it, and documents it." "Nursing setting up medications and monitoring [R5's] response to medication, including new ordering or refill medication to the provider or Pharmacy. Monitoring daily dose response by direct RN [registered nurse] Support. ULP [unlicensed personnel] Staff as delegated by RN." R5's Discharge Summary completed on March 15, 2024, did not include a medication disposition form. On August 21, 2024, at 11:08 a.m., CNS-C stated R5 never took medication while they were residing at the licensee's facility. The surveyor inquired why the service plan and the customized living rates worksheet indicated R5 had received medication administration and medication set up service, if R5 never took medications. CNS-C stated, "My understanding is that we put the services we offer on the service plan, and on the rate sheet, in case they [referring to the licensee's residents] need it [referring to the services] we are ready to manage those services for them." The licensee's Service Plan for Medication Management Policy dated August 1, 2022, indicated, "Policy Statement: Comfort Care Homes will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. Procedure: 1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication	01640			

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01640	Continued From page 39 management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. 2. The Registered Nurse is responsible for preparing and documenting the Medication Management Plan. 3. The Medication Management Plan will be kept current and updated with any changes. 4. The Registered Nurse will review the Medication Management Plan as part of the Service Plan with the resident, the resident's designated representative and/or the resident's legal representative prior to implementation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01750	Continued From page 40	01750			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; 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 specific and accurate medication administration instructions for each resident was documented in the resident's record for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 admitted to the licensee and began receiving assisted living services on August 2, 2024.	01750			

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01750	Continued From page 41 R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder. R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R2's Admission Assessment completed on August 18, 2024, indicated R2 needed full medication management and setup. The assessment also indicated R2 needed to be given medications at schedule times and injectables as ordered. R3 R3 admitted to the licensee and began receiving assisted living services on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R3's Admission Assessment completed on August 18, 2024, indicated R3 needed full medication management and setup. The assessment also indicated medication self-administration is not applicable for R3.	01750			

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01750	Continued From page 42 On August 20, 2024, at 9:15 a.m., the surveyor observed R3's medication administration performed by ULP-B. ULP-B administered aripiprazole 5mg and olanzapine 5mg PRN (as needed), per R3's request. ULP-B also attempted to give Metformin 500mg; R3 declined metformin and stated they get metformin at bedtime. The surveyor inquired if R3 had been taking it at bedtime and R3 stated yes, they had been taking metformin at bedtime. On August 20, 2024, at 9:15 a.m., the surveyor observed R3's electronic medication administration record (eMAR) indicated, "Metformin Tab 500mg Er (Daily) Take 1 tablet by mouth at bedtime with a meal. indications: antipsychotic therapy- induced weight gain. *1 total fill*. (Starts: 08/18 11:00 AM)". Although it was indicated in the order for the medication to be administered at bedtime, the medication administration time was entered for administration at 11:00 a.m., daily. On August 20, 2024, at 9:30 a.m., CNS-C stated the medication administration time was entered into Rtasks (eMAR software) was wrong. CNS-C stated they would fix the time. On August 21, 2024, at 11:42 a.m., the surveyor observed R2's eMAR indicated, "Lithium Carbonate (Daily) 450mg Take 2 tablets by mouth daily at bedtime (Starts: 08/19 11:59 AM)". Although it was indicated in the order for the medication to be administered at bedtime, the medication administration time was entered for 10:00 a.m., daily. On August 21, 2024, at approximately 11:45 a.m., CNS-C stated R2 knows to take it at bedtime; it is also written on the label and staff knew to check	01750			

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01750	Continued From page 43 the labels. CNS-C also stated, "I will update it". The licensee's 7.15 Medication and Treatment - Administration & Delegation policy dated August 1, 2021, read: " POLICY: Ordered or prescribed medications and or treatments/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or to perform the treatment or therapy, or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse at Comfort Care Homes LLC PROCEDURE: When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, Comfort Care Homes LLC 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 3. Communicated with the unlicensed personnel about the individual needs of the resident. Prior to a ULP providing delegated medication administration and/or treatments/therapy, the following must occur: 1. A RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided. 2. Comfort Care Homes LLC will prepare and	01750			

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01750	Continued From page 44 include in the Service Plan a written statement of the medication management or treatment/therapy services that will be provided to the resident. 3. The medications have current prescriber's orders on file. 4. A RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. 5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. 7. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			

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01760	Continued From page 45	01760			
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 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 document medication administration for two of three residents (R1, R2) and failed to accurately transcribe medications for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MISSING DOCUMENTATION	01760			

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NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2521 12TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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
01760	Continued From page 46 R1 R1 was admitted to the licensee and began receiving assisted living services on April 29, 2020. R1's service plan signed on May 19, 2023, indicated R1 received assistance with housekeeping, laundry, bathing, grooming, dressing, meals, medication set up, medication administration, behavior management, and toileting. R1's Medication Recap Summary form August 1, 2024, through August 19, 2024, lacked documentation of medication administration for August 11 and 12, 2024. On August 19, 2024, at 1:21 p.m., clinical nurse supervisor (CNS)-C stated R1 informed them they were on leave of absence via telephone and refused to come back to the facility to take their medications for August 11 and 12, 2024. CNS-C stated the R1's medication refusal was supposed to be charted as declined. CNS-C also stated they had reeducated staff on medication charting. R2 R2 admitted to the licensee and began receiving assisted living services on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder. R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and	01760			

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01760	Continued From page 47 record vital signs. R2's admission assessment completed on August 18, 2024, indicated R2 needed full medication management and setup. The assessment also indicated R2 needed to be given medications at schedule times and injectables as ordered. R2's Medication Administration Summary for the month of August 2024, indicated the licensee implemented the following medications for administration by the licensee's staff on August 19, 2024: - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - olanzapine 2.5mg, take 1 tablet daily; - prenatal plus 27-1mg, take 1 tab daily; - triamcinolone Acetonide 0.1%, apply a thin amount to affected area twice daily; - risperidone 1mg, take 1 tab twice daily; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; and - olanzapine (no dosage) take 1-2 tabs twice daily as needed (PRN) with doses 6 hours apart. R2's progress note dated August 14, 2024, indicated R2 received risperidone injection to R2's left deltoid. On August 21, 2024, at approximately 9:50 a.m., CNS-C stated R2 had been getting their medication, but the medication administration service was not entered into the system until August 18, 2024. The surveyor inquired, who was administering the medication to R2. CNS-C stated themselves and the unlicensed personnel (ULPs) had been administering the medications. The surveyor inquired how ULPs would know what to administer, when to administer, and how the ULPs documented medication administration.	01760			

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01760	Continued From page 48 CNS-C stated the five right rules were posted on the medication cabinet for the ULPs to refer to, and the resident's name, the name of the medication, dosage and administration time were written on the medication labels. CNS-C also stated the ULPs were supposed to paper chart medication administration and stated they would check if they had the record of it. The surveyor inquired if the CNS had paper charted when they administered medications. CNS stated they should have paper charted medication administrations, but they had not. CNS-C did not provide any paper charting for R2's medication administration. Aside of a progress note documenting a risperidone injection on August 14, 2024, R2's record lacked documentation staff administered R2's medications. TRANSCRIPTION ERROR R2 R2's medication administration summary dated August 19, 2024, through August 20, 2024, indicated the following medication orders: - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - olanzapine 2.5mg, take 1 tablet daily; - prenatal plus 27-1mg, take 1 tab daily; - triamcinolone Acetonide 0.1%, apply a thin amount to affected area twice daily; - risperidone 1mg, take 1 tab twice daily; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; and - olanzapine (no dosage) take 1-2 tabs twice daily as needed (PRN) with doses 6 hours apart. R2's [pharmacy name] Prescription Transfer Report sent to the licensee via fax on August 20,	01760			

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01760	Continued From page 49 2024, indicated the following prescription orders for R2: - vitamin D3 1,000unit (u) capsule (cap), take 1 cap by mouth every morning; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; - prenatal plus 27-1mg, take 1 tab daily; - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - risperidone 50mg/2 milliliters(ml) vial, inject 50mg intramuscularly every two weeks; and - Lybalvi (olanzapine and samidorphan) 10-10mg tab, take 1 tab at bedtime. R2's August 2024 medication administration record (MAR) included risperidone 1mg, and olanzapine scheduled and PRN; risperidone and olanzapine were not listed on the prescription medication list from the pharmacy. In addition, R2's MAR omitted vitamin D3, Risperidone injection and Lybalvi. On August 21, 2024, at 11:37 a.m., CNS-C stated they called the pharmacy and learned there was no current order for risperidone 1mg tab. On August 21, 2024, at approximately 11:50 a.m., the surveyor inquired why R2's MAR omitted vitamin D3, risperidone injection, and Lybalvi. CNS- stated "I do not know what the pharmacy is doing, they are supposed to put it in the MAR." CNS-C also stated the pharmacy gets the orders from the physicians and enter the orders into Rtasks for the licensee. On August 21, 2024, at approximately 11:55 a.m., the surveyor called the licensee's pharmacy and inquired if they had entered the medication orders for the licensee's resident into Rtasks. Pharmacy (P)-F stated the pharmacy had an active	01760			

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01760	Continued From page 50 medication list, and if the licensee used the electronic medical record, they received a notification whenever there were new orders. P-F also stated the system requires the licensee to go into their electronic medication administration record (eMAR) and accept the change for the medication orders to show on the licensee's eMAR medication list. R2's MAR indicated Risperidone 1mg tab was administered, on August 19 and 20, 2024, during the p.m. shifts. R2's progress note dated August 14, 2024, indicated R2 received risperidone injection to R2's left deltoid. On August 21, 2024, at approximately 12:15p.m., the surveyor inquired if R2 was getting overdosed on risperidone since they had gotten both the injection and the oral form. CNS-C stated the licensed assisted living director (LALD)-D was checking with R2's clinic to see if they had a prescription (order) for the risperidone oral tablet. The licensee never provided an order for the oral risperidone. R3 R3's medication administration summary dated August 18, 2024, through August 20, 2024, indicated the following medication orders: - aripiprazole 5mg, take 1 tab every morning; - metformin 500mg extended release (ER), take 1 tab at bedtime; - olanzapine 10mg, take 1 tab at bedtime; and - olanzapine 5mg, take 1tab daily PRN for agitation or psychosis. On August 20, 2024, at 9:15 a.m., the surveyor observed R3's medication administration	01760			

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01760	Continued From page 51 performed by ULP-B. ULP-B administered aripiprazole 5 mg and olanzapine 5 mg PRN (as needed), per R3's request. ULP-B also attempted to give Metformin 500 mg; R3 declined metformin and stated they get metformin at bedtime. R3's MAR indicated R3 received aripiprazole 5mg, and metformin 500mg on August 18 and 19, 2024, during the a.m. shifts. On August 20, 2024, at 3:02 p.m., via email, the surveyor requested a physician order for R3. On August 21, 2024, at 11:23 a.m., via email the licensee provided R3's [pharmacy name] Prescription Report sent to the licensee via fax on August 21, 2024, at 11:23 a.m., which indicated the following prescription orders for R3: - olanzapine 5mg, take 1tab daily PRN for agitation or psychosis. The licensee was unable to provide a signed physician order for the additional medications transcribed into the licensee's MAR except olanzapine, PRN. The licensee's 7.20 Medication Management and Treatment Orders policy dated August 1, 2020, read: " POLICY: To ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. PROCEDURE: 1) The RN is responsible for assuring that: a. current, authorized prescriber orders for	01760			

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01760	Continued From page 52 medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A resident's MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance."	01760			

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01760	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of a medication setup for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 admitted to the licensee and began receiving assisted living services on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder.	01770			

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01770	Continued From page 54 R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R2's Admission Assessment completed on August 18, 2024, indicated R2 needed full medication management and setup. The assessment also indicated R2 needed to be given medications at schedule times and injectables as ordered. On August 20, 2024, at 12:00 p.m., unlicensed personnel (ULP)-B provided handwritten progress notes and stated that was what registered nurse (RN)-E used for medication set up. R2's progress notes dated August 17, 2024, written by RN-E read, "Writer came to do medication setup." R3 R3 admitted to the licensee and began receiving assisted living services on July 23, 2024. R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs.	01770			

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01770	Continued From page 55 R3's Admission Assessment completed on August 18, 2024, indicated R3 needed full medication management and setup. The assessment also indicated medication self-administration was not applicable for R3. R3's progress note dated July 27, 2024, at 11:00 a.m., indicated RN-E "checked [R3's] medication. [R3] has been taking [their] own medication at bedtime. Will continue that for the present time." R3's progress notes dated July 29, and August 4, 2024, indicated RN-E checked R3's medication supply, and noted R3 had adequate supply of all their medications, on both days. R2 and R3's medication administration record (MAR) set up by the RN for the month of August 2024, lacked the following required information: - name of medication; - times to be administered; - quantity of dose to be administered; and - route of administration. On August 20, 2024, clinical nurse supervisor (CNS)-C stated they were not aware of the required contents for medication set up documentation. CNS-C also stated they would review the statute requirements with RN-E. CNS-C stated going forward they would move away from paper charting and start utilizing the electronic platform. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			

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01820	Continued From page 56	01820			
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 by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 admitted to the licensee and began receiving assisted living services on August 2, 2024. R2's diagnoses included schizophrenia, schizoaffective disorder, and bipolar disorder. R2's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and	01820			

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01820	Continued From page 57 record vital signs. R2's Admission Assessment completed on August 18, 2024, indicated R2 needed full medication management and setup. The assessment also indicated R2 needed to be given medications at schedule times and injectables as ordered. R2's medication administration summary dated August 19, 2024, through August 20, 2024, indicated the following medication orders: - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - olanzapine 2.5mg, take 1 tablet daily; - prenatal plus 27-1mg, take 1 tab daily; - triamcinolone Acetonide 0.1%, apply a thin amount to affected area twice daily; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; and - olanzapine (no dosage) take 1-2 tabs twice daily as needed (PRN) with doses 6 hours apart. R2's [pharmacy name] Prescription Transfer Report sent to the licensee via fax on August 20, 2024, (during the survey) indicated the following prescription orders for R2: - vitamin D3 1,000 unit (u) capsule (cap), take 1 cap by mouth every morning; - melatonin 3mg, take 2 tabs by mouth daily at bedtime; - prenatal plus 27-1mg, take 1 tab daily; - lithium carbonate 450 milligrams(mg), take 2 tablets (tab) daily at bedtime; - risperidone 50mg/2 milliliters(ml) vial, inject 50mg intramuscularly every two weeks; and - Lybalvi 10-10mg tab, take 1 tab at bedtime. R2's August 2024 medication administration record (MAR) included risperidone 1mg, and	01820			

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01820	Continued From page 58 olanzapine scheduled and PRN; risperidone and olanzapine were not listed on the prescription medication list from the pharmacy. In addition, R2's MAR omitted vitamin D3, risperidone injection and Lybalvi. On August 21, 2024, at 11:37 a.m., CNS-C stated they called the pharmacy and learned there was no current order for risperidone 1mg tab. On August 21, 2024, at approximately 11:50 a.m., the surveyor inquired why R2's MAR omitted vitamin D3, risperidone injection, and Lybalvi. CNS- stated "I do not know what the pharmacy is doing, they are supposed to put it in the MAR." CNS-C also stated the pharmacy gets the orders from the physicians and enter the orders into Rtasks for the licensee. On August 21, 2024, at approximately 11:55 a.m., the surveyor called the licensee's pharmacy and inquired if they had entered the medication orders for the licensee's resident into Rtasks. Pharmacy (P)-F stated the pharmacy had an active medication list, and if the licensee used the electronic medical record, they received a notification whenever there were new orders. P-F also stated the system requires the licensee to go into their electronic medication administration record (eMAR) and accept the change for the medication orders to show on the licensee's eMAR medication list. The licensee failed to maintain current written or electronically recorded prescriptions for R2's medications. R3 R3 admitted to the licensee and began receiving assisted living services on July 23, 2024.	01820			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 12TH AVENUE SOUTH MINNEAPOLIS, MN 55404			
(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
01820	Continued From page 59 R3's diagnosis included schizophrenia and substance abuse. R3's service plan dated August 6, 2024, included the following services: appointment reminders, bathing assistance, dressing, grooming, housekeeping, incontinence care, laundry, manage behaviors, medication set up by registered nurse (RN) one day a week, and record vital signs. R3's Admission Assessment completed on August 18, 2024, indicated R3 needed full medication management and setup. The assessment also indicated medication self-administration is not applicable for R3. R3's medication administration summary dated August 18, 2024, through August 20, 2024, indicated the following medication orders: - aripiprazole 5mg, take 1 tab every morning; - metformin 500mg extended release (ER), take 1 tab at bedtime; - olanzapine 10mg, take 1 tab at bedtime; and - olanzapine 5mg, take 1tab daily PRN for agitation or psychosis. On August 20, 2024, at 9:15 a.m., the surveyor observed R3's medication administration performed by ULP-B. ULP-B administered aripiprazole 5 mg and olanzapine 5 mg PRN (as needed), per R3's request. ULP-B also attempted to give Metformin 500 mg; R3 declined metformin and stated they get metformin at bedtime. R3's MAR indicated R3 received aripiprazole 5mg, and metformin 500mg on August 18 and 19, 2024, during the a.m. shifts.	01820			

Minnesota Department of Health

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01820	Continued From page 60 On August 20, 2024, at 3:02 p.m., via email, the surveyor requested a physician order for R3. On August 21, 2024, at 11:23 a.m., via email the licensee provided R3's [pharmacy name] Prescription Report sent to the licensee via fax on August 21, 2024, (during the survey) at 11:23 a.m., indicated the following prescription orders for R3: - olanzapine 5mg, take 1tab daily PRN for agitation or psychosis. The licensee was unable to produce a prescription signed by the physician for all of the medications listed on the MAR except for the olanzapine 5mg, PRN order. The licensee failed to maintain current written or electronically recorded prescriptions for R3's medications. The licensee's Medication Orders policy dated August 1, 2022, read: " Policy Statement: [license name] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act. Procedure: 1. [license name] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. 3. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. a. The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy	01820			

Minnesota Department of Health

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01820	Continued From page 61 provider a prescription drug order by a practitioner authorized to prescribe drugs or devices b. The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy c. Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency i. Immediate administration of the controlled substance is necessary for the proper treatment of the intended user ii. No appropriate alternative treatment is available iii. It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy 4. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. 5. All prescriptions and orders received by [license name] either verbally, in writing or electronically will be kept confidential. 6. When staff become aware of any medications or dietary supplements being used by a resident that are not included in the assessment, the information will be documented, and the RN will be notified. [license name] has determined not to require a prescription for over-the- counter medications and dietary supplements. These medications will be included on the Medication Profile annually renewed by the physician." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

Minnesota Department of Health

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01890	Continued From page 62	01890			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened and name of the resident and failed to discard expired medication for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving assisted living services on April 29, 2020. R1's service plan signed on May 19, 2023, indicated R1 received assistance with housekeeping, laundry, bathing, grooming, dressing, meals, medication set up, medication	01890			

Minnesota Department of Health

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01890	Continued From page 63 administration, behavior management, and toileting. R1's recorded included Individualized Medication Management Plan completed on March 8, 2023. EXPIRED MEDICATION, NO NAME LABEL, and NO OPENED-ON DATE On August 20, 2024, at 11:36 a.m., the surveyor observed albuterol sulfate HFA (Proair) inhalation with no name label, and no opened-on date in the medication cabinet along with other medications for R1 in a clear plastic storage bin. The surveyor also observed the Albuterol sulfate HFA inhalation which expired June 2024. On August 20, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-C confirmed the albuterol sulfate HFA inhalation was for R1. CNS-C also stated the medication was supposed to have a label with opened on date and the expiry date should have been checked and discarded by the nurse, but it was overlooked. The manufacturer's instructions for the use of albuterol sulfate HFA inhaler last revised December 2023, read, "Up to two years' expiration ProAir® HFA offers up to 24 months before expiration. The inhaler may be used for up to two years or 200 doses, whichever comes first.** ** The expiration date of your inhaler is important. You should check your expiration date and replace your inhaler prior to the date shown on your inhaler canister." The licensee's Service Plan for Medication Management Policy dated August 1, 2022, read, "Policy Statement: Comfort Care Homes will	01890			

Minnesota Department of Health

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01890	Continued From page 64 prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. Procedure: 1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. 2. The Registered Nurse is responsible for preparing and documenting the Medication Management Plan. 3. The Medication Management Plan will be kept current and updated with any changes. 4. The Registered Nurse will review the Medication Management Plan as part of the Service Plan with the resident, the resident's designated representative and/or the resident's	01890			

Minnesota Department of Health

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01890	Continued From page 65 legal representative prior to implementation." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. 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:	03090			

Minnesota Department of Health

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03090	Continued From page 66 On August 19, 2024, at 9:40 a.m., upon entering the assisted living facility (ALF), the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On August 19, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-C stated the facility door recently was painted and the electronic monitoring sign was removed. ULP-A posted an electronic monitoring sign that did not include the statutory required language at 12:00 p.m. The licensee's Electronic Monitoring policy dated August 1, 2022, indicated the licensee would post a sign at each facility entrance accessible to visitors that read: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 08/20/24
Time: 11:00:00
Report: 8041241153

Food and Beverage Establishment Inspection Report

Page 1

Location:

Comfort Care Homes
2521 12th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0037502
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129782108
ID #:

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

The following orders were issued during this inspection.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C **** Priority 2 ****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
A FEW COCKROACHES OBSERVED ON THE RIGHT SIDE OF THE COUNTER BEHIND EQUIPMENT IN THE KITCHEN. CONTINUE WORKING WITH LICENSED PEST CONTROL COMPANY.

Comply By: 08/20/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

SEAL ANY GAPS/OPENINGS IN THE KTICHEN AREA, INCLUDING HOLE IN WALL AROUND ELECTRICAL OUTLET. REMOVE OR PUT AWAY ANY UNUSED EQUIPMENT TO ALLOW EASY CLEANING AND INSPECTION FOR PESTS.

Comply By: 08/20/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COUNTER SURFACE AND SURROUNDING AREA WHERE COCKROACHES WERE FOUND NEEDS TO BE CLEANED.

Comply By: 08/20/24

Type: Full
Date: 08/20/24
Time: 11:00:00
Report: 8041241153
Comfort Care Homes

Food and Beverage Establishment
Inspection Report

Utensil Surface Temp.: = at 167 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: whirlpool refrigerator: turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: whirlpool refrigerator: milk
Violation Issued: No

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

Inspection was completed with Deka Abdulle. Derartu Mosissa was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

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

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

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

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

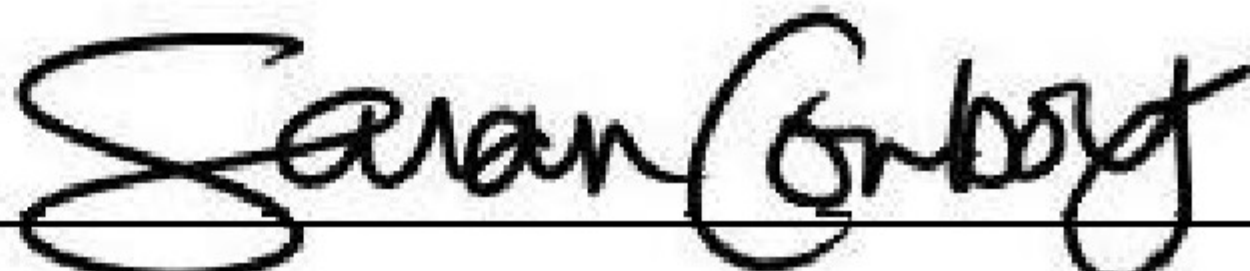
I acknowledge receipt of the Minnesota Department of Health inspection report number 8041241153 of 08/20/24.

Certified Food Protection Manager Fatumo M. Abdi

Certification Number: fm111230 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Deka Abdulle
Manager

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