



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

September 12, 2025

Licensee
Volante of Hanover
10875 Settlers Lane
Hanover, MN 55341

RE: Project Number(s) SL32913016

Dear Licensee:

Please Note: This notice amends the previous notice dated March 4, 2025. Specifically, the fine imposed on tag 1290 is being rescinded. As a result of the rescinded fine, language related to fine imposed is removed from this notice. Further, your right to request a reconsideration had expired with the previous notice dated March 4, 2025. There have been no other changes made.

The Minnesota Department of Health (MDH) completed a survey on January 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

INFORMAL CONFERENCE

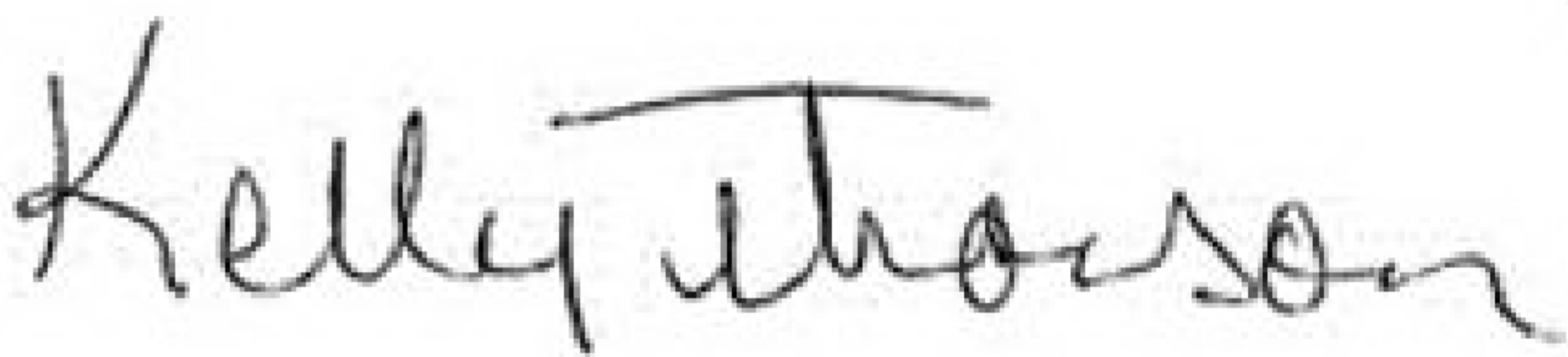
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Volante of Hanover. Please contact Kelly Thorson at 320-223-7336 on or before **March 7, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 10, 2025

Licensee
Volante of Hanover
10875 Settlers Lane
Hanover, MN 55341

RE: Project Number(s) SL32913016

Dear Licensee:

On June 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 24, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 4, 2025

Licensee
Volante of Hanover
10875 Settlers Lane
Hanover, MN 55341

RE: Project Number(s) SL32913016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

Volante of Hanover

March 4, 2025

Page 3

the website listed above.

INFORMAL CONFERENCE

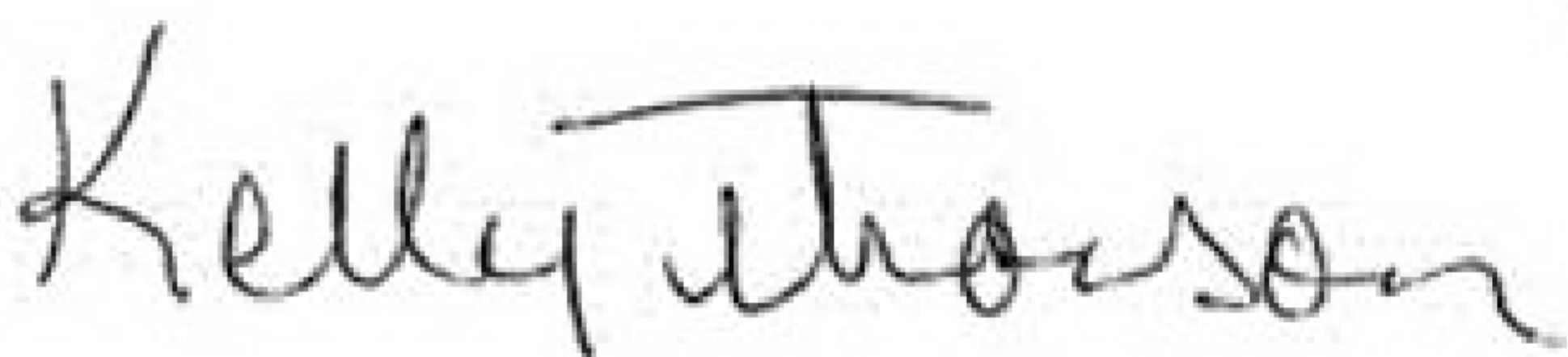
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Volante of Hanover. Please contact Kelly Thorson at 320-223-7336 on or before **March 7, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Thorson". The signature is written in dark ink and is positioned below the word "Sincerely,".

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
(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 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: SL32913016-0 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 resident(s); all of whom were receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		

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: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
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0 420	Continued From page 1	0 420			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license, effective November 1, 2021. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that,	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
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0 420	Continued From page 2 as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page four was electronically signed by the authorized agent on July 31, 2024. As a result of this survey, the following orders were issued under 0420, 0470, 0500, 0630, 0650, 0680, 0720, 0730, 0775, 0810, 1060, 1290, 1370, 1380, 1440, 1470, 1500, 1540, 1620, 1730, 1750, 1910, 1940, and 2170 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			

Minnesota Department of Health

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0 470	Continued From page 3	0 470			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the 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 in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 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 the potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 12:52 p.m. during the entrance conference, clinical nurse supervisor (CNS)-D acknowledged that she did not develop and implement a written staffing plan twice a year and stated, "We have a staffing plan listed on the UDALSA, [uniform Disclosure of Assisted Living Services and Amenities] but I wasn't aware that Minnesota had an acuity based staffing plan requirement, so I suppose I am the one that should do it." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
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0 500	Continued From page 5	0 500			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 500			

Minnesota Department of Health

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0 500	Continued From page 6 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 7:45 a.m., the surveyor emailed the licensee that an onsite assisted living facility survey would be initiated on January 21, 2025, at 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -annual training; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting ongoing resident evaluations and assessments of resident needs, including	0 500			

Minnesota Department of Health

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0 500	Continued From page 7 assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - ensuring that nurses and licensed health professionals have current and valid licenses to practice. From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630			

Minnesota Department of Health

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0 630	Continued From page 8 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted and began receiving assisted living services on June 18, 2024. R2's record included a Residency Agreement signed by R2's legal representative on August 27, 2024. R2's record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse.	0 630			

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NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
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0 630	Continued From page 9 R3 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On January 22, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-D stated, "So, I know the new forms that were created in August, I believe, they ask the question of being at risk to abuse others. I have not seen it on the old forms, but the new forms have it." CNS-D then indicated if it wasn't found on the old form for one resident it would also be missing for all residents on the old form. From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

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0 650	Continued From page 10	0 650			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 650			

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0 650	Continued From page 11 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired November 5, 2018, to provide direct cares and services to residents. On January 21, 2025, at 12:26 p.m., the surveyor observed ULP-B administer medications to R2. ULP-B's employee records contained an annual review dated November 10, 2023, though lacked an annual performance review for 2024. On January 23, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-D indicated annual evaluations were not completed and stated, "No particular reason other than I just need to get them done and I have not had time to do them. There are only two that need to be done, but I have not gotten to them." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 680	Continued From page 12	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the Provisional Assisted Living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - develop policies/procedures (P/P) that address to use volunteers, including the process/role for integration and other emergency staffing strategies in its emergency plan; and - develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. On January 23, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-D stated, "I have no idea (why there is missing items). These are things that don't apply to the nurse other than the patient population, so I would have no idea." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 720	Continued From page 14	0 720			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 8:30 a.m., the surveyor called the facility to initiate survey. Concierge/administration (C/A)-K confirmed LALD-C and CNS-D's emails, and noted LALD-C was unavailable this week, and CNS-D was not currently available. On January 21, 2025, at 9:20 a.m., CA -K acknowledged they did not have access to	0 720			

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0 720	Continued From page 15 resident or employee records, however CNS-D would be arriving at approximately 12:00 p.m. On January 21, 2025, at 12:36 p.m., CNS-D arrived at the facility and the entrance conference was started. On January 21, 2025, at 1:09 p.m., an email was sent to CNS-D requesting all files for R2 and R3. On January 22, 2025, at 7:22 a.m., C/A-K indicated CNS-D would not be in until 9:30 a.m. On January 22, 2025, at 9:35 a.m., CNS-D arrived at the facility and surveyor requested all the previously requested files for R2 and R3 be made available. On January 22, 2025, at 11:10 a.m., surveyor made a third request for the missing records for R2 and R3. On January 22, 2025, at 1:43 p.m., surveyor made a fourth request for the missing records for R2 and R3 via email. On January 22, 2025, at 3:16 p.m., CNS-D stated she would be available the following day at approximately 9:30 a.m. to provide requested records to the surveyor. On January 23, 2025, at 11:31 a.m., surveyor made a fifth request for the missing records for R2 and R3 via email and CNS-D provided R2 files. On January 23, 2025, at 1:20 p.m., surveyor made a sixth and final request for the missing records for R3 via email.	0 720			

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0 720	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
0 730 SS=F	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; (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	0 730			

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0 730	Continued From page 17 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 ensure the resident record included a discharge summary with the required content for two of two discharged residents (R1 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on September 13, 2023. R1 discharged to another facility on February 10,	0 730			

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0 730	Continued From page 18 2024. R5 R5 was admitted to the licensee and began receiving services on August 2, 2023. R5 discharged to another facility on May 28, 2024. R1 and R5's records lacked a discharge summary. On January 2025, at 11:50 a.m., clinical nurse supervisor (CNS)-D stated, "Typically the medications are theirs so I would send it with them, and a progress note is written up about the discharge. I can't say if that was done because I can't find them." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775			

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0 775	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code under Minnesota Rules chapter 7511. 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 the potential to affect a large portion or all of the residents). Findings include: On January 21, 2025, from approximately 11:21 a.m. to 12:20 p.m., the surveyor toured the facility with director of maintenance (DOM)-A. During the tour, the surveyor observed the following: The elevator lobby on the ground floor had a fire rated door assembly replaced with a door that does not display fire rating. The elevator lobby door did not contain required metal identification tag on door nor any labels on door or glass to demonstrate that the assembly was listed as an approved fire rated door by testing agency. DOM-A acknowledged that door appears to be non-rated and stated that it may have been replaced without a properly rated assembly. These deficient conditions were visually verified by DOM-A accompanying on the tour and DOM-A stated they understood requirements.	0 775			

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0 775	Continued From page 20	0 775			
	TIME PERIOD FOR CORRECTION: Two (2) days.				
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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a fire safety and evacuation plan (FSEP) in a readily available location. 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 January 21, 2025, at approximately 12:00 p.m., director of maintenance (DOM)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP was located in the nurses' room behind a locked door. The FSEP was not supplied readily available. FSEP did not include documentation that facility staff received adequate training on FSEP. Employees should receive training on FSEP at least twice a year and upon hire. During the record review and interview on January 21, 2025, DOM-A verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

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0 810	Continued From page 22 (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060			

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NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER			STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341		
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01060	Continued From page 23 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for two of two residents (R6 and R7). 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: R6 R6 was admitted to the licensee and began receiving assisted living services on November 27, 2023. R6's unsigned Service Plan, indicated R6 received services including assistance with medication administration.	01060			

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01060	Continued From page 24 On January 23, 2025, at 10:48 a.m., clinical nurse supervisor (CNS)-D sent an email indicating R6 had been hospitalized on January 8, 2025, and had not yet returned to the licensee. R6's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. R7 R7 was admitted to the licensee and began receiving assisted living services on December 7, 2021. R7's signed Service Plan dated July 25, 2023, indicated R7 received services including assistance with medication administration. On January 23, 2025, at 10:48 a.m., clinical nurse supervisor (CNS)-D sent an email indicating R7 had been hospitalized on December 19, 2024, through December 24, 2024. R7's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On January 21, 2025, at 1:06 p.m., during the entrance conference, CNS-D acknowledged they did not realize emergency relocation forms were a regulation requirement and stated, "No I do not do an emergency relocation forms for anyone who has been hospitalized." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living	01060			

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01060	Continued From page 25 director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	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. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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 a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of twenty-six employees (unlicensed personnel (ULP)-G). This practice resulted in a level three violation (a	01290			

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01290	Continued From page 26 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-G was hired on April 23, 2024, to perform direct care services to the licensee's residents. On January 21, 2025, at 2:26 p.m., business office manager (BOM)-E provided the surveyor via email with the facility's NetStudy 2.0 (a web-based system used to submit background study requests to the Department of Human Services (DHS)) roster. The licensee's schedule dated January 19, 2025, through January 25, 2025, indicated ULP-G had worked January 19 and 20, 2025, and was scheduled to work January 22, 2025, through January 25, 2025. ULP-G's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID 32913, effective August 1, 2021. On January 22, 2025, at 9:34 a.m., BOM-E indicated via email, "I am not seeing one for [ULP-G]." surveyor asked BOM-E and licensed assisted living director via email if they knew why there was no background study completed for ULP-G, and on January 22, 2025, at 10:42 a.m., BOM-E indicated via email, "No, I'm not sure. I will have her sign a consent and run her through	01290			

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01290	Continued From page 27 the system." On January 22, 2025, at 10:13 a.m., surveyor requested a policy on background studies and clinical nurse supervisor (CNS)-D indicated via email, "Both myself and the business office manager are unable to find a policy on background checks." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370			

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01370	Continued From page 28 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for five of six unlicensed personnel ((ULP)-F, ULP-G, ULP-H, ULP-I, and ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired on April 23, 2024, to provide direct care services to residents.	01370			

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01370	Continued From page 29 On January 22, 2025, from 8:10 a.m. through 8:50 a.m., surveyor observed ULP-F assist residents with breakfast. ULP-G ULP-G was hired on April 23, 2024, to provide direct care services to residents. ULP-H ULP-H was hired on October 22, 2024, to provide direct care services to residents. ULP-I ULP-I was hired on October 22, 2024, to provide direct care services to residents. ULP-J ULP-J was hired on October 22, 2024, to provide direct care services to residents. ULP-F, ULP-G, ULP-H, ULP-I and ULP-J's employee records lacked documentation of training and competency evaluations for ULP's providing assisted living services including: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and	01370			

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01370	Continued From page 30 - dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On January 22, 2025, at 12:46 p.m. clinical nurse supervisor (CNS)-D stated, "[ULP-G], she is a care giver so she would not have had the training, and I only do delegation on meds no cares. [ULP-I], I did not do delegation training with her because she does not pass meds, and I don't do it on cares. I can pull her record, but I am telling you I did not do the training on cares with her. [ULP-H] has been delegated on meds but again I didn't do it for any cares. [ULP-J] again no training by me." On January 22, 2025, at 1:25 p.m., ULP-F stated, "For training on the floor I came in the first day I was trained on the floor with [ULP-B], the nurse asked me if I had passed meds before and I had, so she said ok. I would shadow [ULP-B] but before I could do that, she (the nurse) had to show me how to do the meds and then she	01370			

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01370	Continued From page 31 signed me off. [ULP-B] showed me how to do the cares how to do the gloves and teeth brushing and dentures and how to position the resident and all those things. On January 22, 2025, at 1:44 p.m., ULP-I stated, "I started in October, [ULP-B] trained me on cares, and I learned a lot from her. I was not trained by her (the nurse) at all, no, it was only [ULP-B] that trained me, and the nurse watched no cares be done by me." On January 22, 2025, at 3:15 p.m., ULP-J stated, "I started the end of October, I did [observation] and then I did hands on with [two other ULPs]." When asked if the nurse ever did any training or competency training during her orientation timeframe, ULP-B stated, "No, I did didn't really need anything as I had experience before. I did all the Relias (a computer training software) courses, but I never sat down with anyone." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380			

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01380	Continued From page 32 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for five of six unlicensed personnel ((ULP)-F, ULP-G, ULP-H, ULP-I, and ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired on April 23, 2024, to provide	01380			

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01380	Continued From page 33 direct care services to residents. On January 22, 2025, from 8:10 a.m. through 8:50 a.m., surveyor observed ULP-F assist residents with breakfast. ULP-G ULP-G was hired on April 23, 2024, to provide direct care services to residents. ULP-H ULP-H was hired on October 22, 2024, to provide direct care services to residents. ULP-I ULP-I was hired on October 22, 2024, to provide direct care services to residents. ULP-J ULP-J was hired on October 22, 2024, to provide direct care services to residents. ULP-F, ULP-G, ULP-I and ULP-J's employee records lacked the following training and competency evaluations: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required.	01380			

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01380	Continued From page 34 ULP-H's employee records lacked the following training and competency evaluations: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On January 22, 2025, at 12:46 p.m. clinical nurse supervisor (CNS)-D stated, "[ULP-G], she is a care giver so she would not have had the training, and I only do delegation on meds no cares. [ULP-I], I did not do delegation training with her because she does not pass meds, and I don't do it on cares. I can pull her record, but I am telling you I did not do the training on cares with her. [ULP-H] has been delegated on meds but again I didn't do it for any cares. [ULP-J] again no training by me." On January 22, 2025, at 1:25 p.m., ULP-F stated, "For training on the floor I came in the first day I was trained on the floor with [ULP-B], the nurse asked me if I had passed meds before and I had, so she said ok. I would [observe ULP-B] but before I could do that she (the nurse) had to show me how to do the meds and then she signed me off. [ULP-B] showed me how to do the cares how to do the gloves and teeth brushing and dentures and how to position the resident and all those things." On January 22, 2025, at 1:44 p.m., ULP-I stated,	01380			

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01380	Continued From page 35 "I started in October, [ULP-B] trained me on cares, and I learned a lot from her. I was not trained by her (the nurse) at all, no, it was only [ULP-B] that trained me, and the nurse watched no cares be done by me." On January 22, 2025, at 3:15 p.m., ULP-J stated, "I started the end of October, I did [an observation day] and then I did hands on with [two other ULPs]." When asked if the nurse ever did any training or competency training during her orientation timeframe, ULP-B stated, "No, I did didn't really need anything as I had experience before. I did all the Relias (a computer training software) courses, but I never sat down with anyone." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being	01440			

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01440	Continued From page 36 provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel within 30 calendar days of beginning to provide delegated tasks for five of six unlicensed personnel ((ULP)-F, ULP-G, ULP-H, ULP-I, and ULP-J). 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:	01440			

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01440	Continued From page 37 ULP-F ULP-F was hired on April 23, 2024, to provide direct care services to residents. On January 22, 2025, from 8:10 a.m. through 8:50 a.m., surveyor observed ULP-F assist residents with breakfast. ULP-G ULP-G was hired on April 23, 2024, to provide direct care services to residents. ULP-H ULP-H was hired on October 22, 2024, to provide direct care services to residents. ULP-I ULP-I was hired on October 22, 2024, to provide direct care services to residents. ULP-J ULP-J was hired on October 22, 2024, to provide direct care services to residents. ULP-F, ULP-G, ULP-H, ULP-I and ULP-J's record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On January 23, 2025, at 12:55 p.m. clinical nurse supervisor (CNS)-D stated, "I do not know why I have not done them." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living	01440			

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01440	Continued From page 38 director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470			

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01470	Continued From page 39 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for five of five employees, (unlicensed personnel (ULP)-F, ULP-G, ULP-H, ULP-I and ULP-J) with employee records reviewed.	01470			

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01470	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired on April 23, 2024, to provide direct care services to residents. ULP-G ULP-G was hired on April 23, 2024, to provide direct care services to residents. ULP-H ULP-H was hired on October 22, 2024, to provide direct care services to residents. ULP-I ULP-I was hired on October 22, 2024, to provide direct care services to residents. ULP-J ULP-J was hired on October 22, 2024, to provide direct care services to residents. ULP-F, ULP-G, ULP-H, ULP-I and ULP-J's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - Overview of Assisted Living statutes; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the	01470			

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01470	Continued From page 41 employee will provide and provider's scope of license. On January 23, 2025, at 1:09 p.m. clinical nurse supervisor (CNS)-D indicated they were unaware why orientation was not completed for the ULP's. CNS-D stated, "I do not know why." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500			

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01500	Continued From page 42 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500			

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01500	Continued From page 43 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-B) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired November 5, 2018, to provide direct care and services to residents. On January 21, 2025, at 12:26 p.m., the surveyor observed ULP-B administer medications to R2. ULP-B's employee records lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; and - Principles of person-centered planning/service delivery On January 23, 2025, at 1:09 p.m., clinical nurse supervisor (CNS)-D stated they were not aware as to why annual training was not completed. CNS-D stated, "No particular reason other than I	01500			

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01500	Continued From page 44 guess I need to research what annual training we need to be doing." CNS-D stated all the ULP's get the same annual training. From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540			

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01540	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure one of six employees (unlicensed personnel (ULP)-B) completed the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-F was hired and began providing assisted living services on April 23, 2024. ULP-Fs employee file contained initial dementia Relias training (an electronic training software) to total seven and a half hours, but lacked eight hours of training on dementia. On January 23, 2025, at 1:09 p.m. clinical nurse supervisor (CNS)-D stated they were unaware orientation was not completed for ULP-B, and was unsure why. From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living	01540			

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01540	Continued From page 46 director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620			

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01620	Continued From page 47 licensee failed to ensure the registered nurse (RN) conducted an admission assessment and a reassessment within 14-days following admission date for three of three residents (R2, R3 and R4), and ongoing nursing assessments not to exceed every 90-days thereafter for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted and began receiving assisted living services on June 18, 2024. R2's record included a Residency Agreement signed by R2's legal representative on August 27, 2024. R2's unsigned Service Plan, effective July 15, 2024, indicated R2's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, bed making, medication administration and meal assistance. R2's record included two unsigned Initial Assessments dated June 19, 2024, and July 12, 2024, which was 23 days after R2's admission date, and an unsigned 30-Day Post Admission (AL) Assessment dated July 15, 2024, which indicated 192 days had passed since R2's last assessment.	01620			

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01620	Continued From page 48 R3 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's unsigned Service Plan, effective May 29, 2024, indicated R3's services included grooming, bathing, dressing, toileting, medication administration and meal assistance. R3's record included an unsigned Initial Assessments dated November 22, 2023, and an unsigned 30-Day Post Admission (AL) Assessment dated January 24, 2024, which indicated 63 days had passed since R3's initial assessment, and an unsigned Quarterly three-month Assessment dated May 23, 2024, which indicated 119 days had passed between assessments and 245 days had passed since R3's last assessment. R4 R4 was admitted and began receiving assisted living services on December 26, 2024. R4's record included a Residency Agreement signed by R3's legal representative on December 26, 2024. R4's unsigned Service Plan, effective December 30, 2024, indicated R4's services included transfer assistance, dressing, bathing, toileting, bed making, medication administration and meal assistance. R3's record included an unsigned Initial	01620			

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01620	Continued From page 49 Assessments dated December 5, 2024, and an unsigned 30-Day Post Admission (AL) Assessment dated January 16, 2025, which indicated 42 days had passed since R4's initial assessment. R2's record included two unsigned Initial Assessments dated June 19, 2024, and July 12, 2024, which was 23 days after R2's admission date, and an unsigned 30-Day Post Admission (AL) Assessment dated July 15, 2024, which indicated 192 days had passed since R2's last assessment. On January 22, 2025, at 11:51 a.m., clinical nurse supervisor (CNS)-D stated most of the resident assessments were late and stated, "I think I have four of them done now? I haven't found time to get them done for almost everyone, I have managed to get a few, but that's it." On January 22, 2025, at 2:01 p.m., licensed assisted living director (LALD)-C stated via phone conversation, "I will be honest with you these are residents that are from before we arrived and there is a reason our last nurse is no longer there. So, I am just going to go out on a limb and say if [CNS-D] can't find them we don't have them." The licensee's Resident Assessment and Service Plans policy dated April 14, 2023, indicated assessments would be completed at the time of admission, 30 days after moving in, every six months thereafter or quarterly where state regulations require it, upon return from alternate care settings, and with any significant change in condition. The policy read, "The Director of Wellness or designee ensures the assessments and service plan are signed and dated by the Community representative, the resident and/or	01620			

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NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER			STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341		
(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
01620	Continued From page 50 responsible party as appropriate and per state regulation." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by	01640			

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01640	Continued From page 51 the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted and began receiving assisted living services on June 18, 2024. R2's record included a Residency Agreement signed by R2's legal representative on August 27, 2024. R2's unsigned Service Plan, effective July 15, 2024, indicated R2's services included mobility assistance, transfer assistance, dressing, grooming, bathing, toileting, bed making, medication administration and meal assistance. R2's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. R3 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement	01640			

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01640	Continued From page 52 signed by R3's legal representative on July 10, 2024 R3's unsigned Service Plan, effective May 29, 2024, indicated R3's services included transfer assistance, dressing, bathing, toileting, bed making, medication administration and meal assistance. R3's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On January 22, 2025, at 11:53 a.m., clinical nurse supervisor (CNS)-D stated, "I have no idea why there are no signed service plans. I get signed service plans when someone new comes in, but I am so shocked at how many don't have signed service plans." When asked how many don't have signed service plans CNS-D stated, "Probably fifty percent, that would be my guess. I don't know why." On January 22, 2025, at 2:01 p.m., licensed assisted living director (LALD)-C stated via phone conversation, "I will be honest with you these are residents that are from before we arrived and there is a reason our last nurse is no longer there. So, I am just going to go out on a limb and say if [CNS-D] can't find them we don't have them." The licensee's Resident Assessment and Service Plans policy dated April 14, 2023, read, "The Director of Wellness or designee ensures the assessments and service plan are signed and dated by the Community representative, the resident and/or responsible party as appropriate	01640			

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01640	Continued From page 53 and per state regulation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730			

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01730	Continued From page 54 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted and began receiving assisted living services on June 18, 2024. R2's record included a Residency Agreement signed by R2's legal representative on August 27, 2024.	01730			

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01730	Continued From page 55 R2's comprehensive assessment that included evaluation of medication management, dated July 15, 2024, lacked a description of person responsible for monitoring medication supplies and refills and procedures for staff to notify an RN when problems arose. R3 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's comprehensive assessment that included evaluation of medication management, dated May 23, 2024, lacked a description of person responsible for monitoring medication supplies and refills and procedures for staff to notify an RN when problems arose. On January 23, 2025, at 1:13 p.m., clinical nurse supervisor stated, "I would agree, it's not in there." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01750	Continued From page 56	01750			
01750 SS=F	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 medication administration instructions for each resident was documented in the resident's record for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10,	01750			

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01750	Continued From page 57 2024 R3's diagnoses included Alzheimer's disease. R3's unsigned Service Plan, effective May 29, 2024, indicated R3's services included transfer assistance, dressing, bathing, toileting, bed making, medication administration and meal assistance. R3's medication administration record dated January 1, 2025, through January 31, 2025, included monitor and record blood glucose twice daily, and Glipizide ER 2.5 milligrams (mg) daily used to treat type 2 diabetes. R3's medication administration record lacked specific medication administration instructions for when to hold the medication or update the nurse. On January 22, 2025, at 2:32 p.m., the surveyor asked the clinical nurse supervisor (CNS)-D how the unlicensed personnel (ULP) would know when to hold the medication, such as for low blood sugar, and where the ULPs would find that information. CNS-D stated, "I guess I didn't realize that needed to be in there, it is not in any of the MAR's or any of the resident's charts." From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, "I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01750			

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01750	Continued From page 58 days	01750			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R1 and R5). This practice resulted in a level two violation (a	01910			

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01910	Continued From page 59 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on September 13, 2023. R1 discharged to another facility on February 10, 2024. On January 22, 2025, at 10:40 a.m. clinical nurse supervisor (CNS)-D stated R1's record lacked a service plan. CNS-D stated, "I can't seem to find her service plan but will keep looking." When asked if R1 would have received medication administration, CNS-D stated, "We do everyone's medication administration here so yes she would have." R5 R5 was admitted to the licensee and began receiving services on August 2, 2023. R5 discharged to another facility on May 28, 2024. R5's unsigned Service Plan, effective February 27, 2024, indicated R5 received medication administration services. R1 and R5's record lacked a medication disposition to include including the medication's	01910			

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01910	Continued From page 60 name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition On January 2025, at 11:50 a.m., clinical nurse supervisor (CNS)-D stated, "Typically the medications are theirs so I would send it with them, and a progress note is written up about the discharge. I can't say if that was done because I can't find them." The licensee's Medication Storage and Disposal policy, dated April 14, 2023, read, "Upon discharge of a resident, the community shall release unused medications to the resident, family member, or responsible party, as appropriate. Documentation of the name, strength, and amount of medication released, along with the signature and date of the person releasing/receiving the unused medications unless specifically prohibited by the attending physician or other authorized health care provider. A copy will be given to the person receiving the medications and the original will be placed in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940			

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01940	Continued From page 61 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include all treatments or therapies ordered for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01940			

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01940	Continued From page 62 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's diagnoses included Alzheimer's disease. R3's unsigned Service Plan, effective May 29, 2024, indicated R3's services included transfer assistance, dressing, bathing, toileting, bed making, medication administration and meal assistance. R3's medication administration record dated January 1, 2025, through January 31, 2025, included monitor and record blood glucose twice daily. R3's comprehensive assessment which included evaluation of treatment and therapies, dated May 23, 2024, lacked: - resident specific instructions related to the treatments/therapy administration; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications	01940			

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01940	Continued From page 63 and/or adverse reactions. On January 23, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-D stated, "If there is a policy I follow that, I would have to look into it more." CNS-D indicated the above-mentioned items would not be found in the resident records as it is not something she had been doing. From January 21, 2025, through January 23, 2025, surveyor requested policies for the survey, no policy was provided to the surveyor. On January 23, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated, ""I haven't been able to find them and if [licensed assisted living director (LALD)-C] isn't sending them then my guess is they don't exist." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be	02170			

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NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
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02170	Continued From page 64 developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R2 and R3) who resided in the secured memory care unit. 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	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
(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
02170	Continued From page 65 of the residents). The findings include: The licensee had an assisted living with dementia care license, effective August 1, 2021. R2 R2 was admitted and began receiving assisted living services on June 18, 2024. R2's record included a Residency Agreement signed by R2's legal representative on August 27, 2024. R2's diagnoses included Alzheimer's disease. R3 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's diagnoses included Alzheimer's disease. R2 and R3's records lacked documentation of evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On January 23, 2025, at 1:18 p.m. clinical nurse supervisor (CNS)-D stated they were unaware	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER VOLANTE OF HANOVER		STREET ADDRESS, CITY, STATE, ZIP CODE 10875 SETTLERS LANE HANOVER, MN 55341			
(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
02170	Continued From page 66 why the licensee's activity assessments were not completed for the residents. CNS-D stated, "There is no other forms that [Licensee] has developed." On January 22, 2025, at 2:01 p.m., licensed assisted living director (LALD)-C stated via phone conversation, "I will be honest with you these are residents that are from before we arrived and there is a reason our last nurse is no longer there. So, I am just going to go out on a limb and say if [CNS-D] can't find them we don't have them." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170			



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: 01/22/25
Time: 14:00:00
Report: 8087251008

Food and Beverage Establishment Inspection Report

Page 1

Location:

Bridgewater At Hanover Llc
10875 Settlers Lane
Hanover, MN55341
Hennepin County, 27

Establishment Info:

ID #: 0039056
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634630708
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 150 Degrees Fahrenheit
Location: DISH MACHINE - 1ST FLOOR KITCHEN
Violation Issued: No

Rinse Temperature Gauge: = -- at 184 Degrees Fahrenheit
Location: DISH MACHINE - 1ST FLOOR KITCHEN
Violation Issued: No

Max Utensil Surface Temp: = -- at 163 Degrees Fahrenheit
Location: DISH MACHINE - 1ST FLOOR KITCHEN
Violation Issued: No

Wash Temperature Gauge: = -- at 168 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR KITCHEN
Violation Issued: No

Rinse Temperature Gauge: = -- at 182 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR KITCHEN
Violation Issued: No

Max Utensil Surface Temp: = -- at 162 Degrees Fahrenheit
Location: DISH MACHINE - 2ND FLOOR KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -7 Degrees Fahrenheit - Location: STAND-UP FREEZER - 1ST FLOOR
Violation Issued: No

Type: Full
Date: 01/22/25
Time: 14:00:00
Report: 8087251008
Bridgewater At Hanover Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: CHICKEN
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 1ST FLOOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: -7 Degrees Fahrenheit - Location: STAND-UP FREEZER - 2ND FLOOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER - 2ND FLOOR
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH COOK PATTI ALBRECHT.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

Type: Full
Date: 01/22/25
Time: 14:00:00
Report: 8087251008
Bridgewater At Hanover Llc

Food and Beverage Establishment Inspection Report

Page 3

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND NURSE EVALUATOR TESA BROWN.

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 8087251008 of 01/22/25.

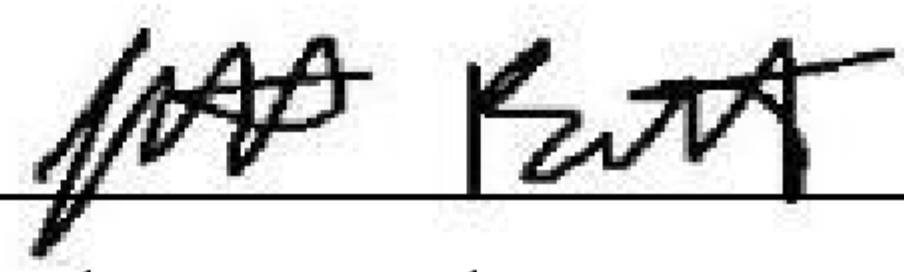
Certified Food Protection Manager ELIZABETH A. JOHNSON

Certification Number: FM90958 Expires: 04/17/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

PATTI ALBRECHT
COOK

Signed:  _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us