



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 26, 2024

Licensee

Elite Nursing Services Inc

3100 Thurber Road

Brooklyn Center, MN 55430

RE: License Number 414159

Health Facility Identification Number (HFID) 36036

Project Number(s) SL36036015

Dear Licensee:

On April 16, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 20, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective April 26, 2024.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the 10262024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 20, 2023, found not corrected at the time of the follow-up survey and/or subject to a penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 16, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per 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).

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

Elite Nursing Services Inc

April 26, 2024

Page 3

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

Sincerely,

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

Rick Michals, J.D.

Interim Assistant Division Director

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/16/2024
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36036015-2 On April 15, 2024, through April 16, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 15, 2024. At the time of the survey, there were three (3) residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No futher action required.	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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{0 810}	Continued From page 2 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 16, 2024, the licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate), but the policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 3 policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on April 16, 2024, at 11:00 a.m., with office manager (OM-C) and LALD-D, they stated they had started to update the policy to include the required information, but hadn't completed the policy update. OM-C stated he understood the areas of his policy that were incomplete and would work on bringing them into compliance. No further information was provided.	{0 810}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

February 29, 2024

Licensee

Elite Nursing Services Inc

3100 Thurber Road

Brooklyn Center, MN 55430

RE: Conditional License Number 414159
Health Facility Identification Number (HFID) 36036
Project Number(s) SL36036015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on February 15, 2024, to determine correction of orders found on the initial survey completed on October 20, 2023. Based on the follow-up survey results you were found to continue not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 60-day conditional license due to expire on **April 29, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

circumstance.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey, completed on October 20, 2023, found not corrected at the time of the February 15, 2024, follow-up and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - \$500.00
0485-Minimum Requirements-144g.41 Subdivision 1. (13)(i)(a)and(c)
0650-Employee Records-144g.42 Subd. 8 - \$500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - \$3,000.00
1370-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (a)
1530-Training In Dementia Care Required-144g.64 - \$500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - \$500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 - \$500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - \$500.00
1830-Renewal Of Prescriptions-144g.71 Subd. 14 - \$500.00

The details of the violations noted at the time of this follow-up completed on February 15, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up completed on February 15, 2024, we identified the following violation(s):

0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3)

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$8,000.00**. 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.

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Elite Nursing Services Inc an extension to the conditional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Elite Nursing Services Inc is in substantial compliance.

The following conditions will remain in effect through the extended conditional license period and apply to the conditional assisted living facility license:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. No new admissions:** Elite Nursing Services Inc will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Elite Nursing Services Inc must provide the Department:
 - i. A list of the names and birthdates of any individuals Elite Nursing Services Inc is

currently in the process of admitting. These individuals will be able to continue the admittance process.

- ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Elite Nursing Services Inc will continue to contract with an RN to provide consultation concerning all resident(s) to whom Elite Nursing Services Inc provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Elite Nursing Services Inc. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Elite Nursing Services Inc and MDH must review the RN's credentials and approve the selection. Elite Nursing Services Inc will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to continue to provide guidance to Elite Nursing Services Inc in an effort to help Elite Nursing Services Inc align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Elite Nursing Services Inc will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Elite Nursing Services Inc and the RN consultant about a change. Each report will continue to be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will continue to include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family

- members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).

- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Elite Nursing Services Inc to correct the violations cited during the follow-up survey as well as to determine the overall practice of Elite Nursing Services Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Elite Nursing Services Inc will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE EXTENDED CONDITIONAL LICENSE PERIOD:

MDH will determine if Elite Nursing Services Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the extended 60-day conditional license period. If MDH determines Elite Nursing Services Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Elite Nursing Services Inc's assisted living facility license, and Elite Nursing Services Inc will correct violations identified during the survey to come into substantial compliance. If MDH determines Elite Nursing Services Inc is not in substantial compliance, MDH may take additional enforcement action against Elite Nursing Services Inc, including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

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

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

Elite Nursing Services Inc

February 29, 2024

Page 6

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

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

Sincerely,

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

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

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{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and implemented current policies and procedures. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During licensee's initial survey concluded on October 20, 2023, the following deficient practices were identified and remain contributing	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 3 factors for licensee's failure to correct citations issued during this licensing order follow up survey concluded on February 15, 2024. On October 17, 2023, at 10:30 a.m., office manager (OM)-C stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities.	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 4 - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, 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	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 5 existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Owner/Administrator (OA)-G on June 13, 2023. The licensee had an Assisted Living license issued on October 1, 2023, with an expiration date of September 30, 2024. At the time of the follow up survey, the licensee failed to ensure the following policies and procedures were developed and/or implemented: - staff orientation, training, and competency evaluations; - nursing assessments; - orientation to and implementation of the assisted living bill of rights; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks.	{0 250}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{0 250}	Continued From page 6 As a result of this licensing order follow up survey, the following orders were re-issued: 0250, 0485, 0650, 0680, 0780, 0790, 0810, 0820, 1370, 1530, 1650, 1700, 1760, and 1830. No further information was provided.	{0 250}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and	{0 485}			

Minnesota Department of Health

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{0 485}	Continued From page 7 (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals were offered to the residents daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The licensee also failed to post a menu a week in advance and inform residents in advance of menu changes. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 14, 2024, at 11:15 a.m., licensee's Weekly Meal Planner dated, "Week of: Jan 22-27," was posted on the refrigerator in the common kitchen area. A current menu was not posted and not available upon request of the surveyor. On February 14, 2024, at 11:16 a.m., R2 entered the kitchen area and retrieved a frozen corn dog from the kitchen freezer. R2 proceeded to use the microwave to warm up the corndog and then R2	{0 485}			

Minnesota Department of Health

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{0 485}	Continued From page 8 took the warmed corndog to their room on a plate. On February 14, 2024, at 11:45 a.m., R2 entered the kitchen with the plate the corn dog was taken to their room on and placed the plate on the kitchen counter. R2 then obtained a bag of chips from the cabinet and took the chips back to their room for consumption. On February 14, 2024, 11:58 a.m., licensed assisted living director (LALD)-D stated licensee does not keep the menu up to date as residents prefer to make their own choices for food. LALD-D stated licensee does not provide food options based on the USDA guidelines, but purchases food based on the resident's previous food selection and preferences. No further information provided.	{0 485}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 9 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 interview and record review, the licensee failed to ensure employee records contained the required content to include an annual performance evaluation for three of three employees (unlicensed personnel (ULP)-B, ULP-F, 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: ULP-B ULP-B had a hire date of May 28, 2021. ULP-B's employee record did not contain any performance evaluations. ULP-F ULP-F had a hire date of May 25, 2021. ULP-F's employee record did not contain any	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 10 performance evaluations. ULP-J ULP-J had a hire date of April 22, 2022. ULP-J's employee record did not contain any performance evaluations. On February 14, 2024, at 11:58 a.m., licensed assisted living director (LALD)-D provided each ULP's employee record and stated if any required content was not included in the record, then the licensee had not completed the corrections from the previous survey. LALD-D stated licensee had not corrected all citations from the previously completed survey but were in the process of making corrections. The licensee's undated Performance Evaluations policy indicated a performance evaluation would be completed annually for each employee and the performance review would be maintained in each employee's record. No further information provided.	{0 650}			
{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	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 11 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 plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 14, 2024, at 10:45 a.m., licensed assisted living director (LALD)-D provided licensee's Disaster & Emergency Management	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 12 Plan and stated plan was the entire emergency disaster preparedness plan. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - EPP reviewed and updated annually; - a description of the population served by the licensee; - quarterly review of missing resident policy; - communication plan containing all required elements; - hazard vulnerability assessment; - process for emergency plan collaboration; - subsistence needs for staff and residents; - procedures for tracking evacuated residents and staff; - policies for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy and needs; - long term care family notifications; - emergency prep training program which includes maintain documentation of all EP training and EP training annually; and - emergency preparedness testing requirements. The licensee's Evacuation Plan indicated in the event of an evacuation, the residents would be transported by staff to licensee's main office. The main office was located in a business only building and would not be suitable for a resident to sleep, eat, or maintain medications. On February 15, 2024, at 2:00 p.m., LALD-D stated licensee had not corrected all citations	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 13 from the previously completed survey. LALD-D stated what was presented to the surveyor was all the licensee had completed and if content was missing, to issue a citation and licensee would continue to address the citations. The licensee's undated Emergencies policy indicated the licensee would have individuals and staff trained in techniques to limit the potential for emergency situations and provided with the skills necessary to respond in an emergency situation. No further information provided.	{0 680}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 14 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 13, 2024, at 12:00 p.m., survey staff toured the facility with assisted living director (ALD)-D. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by ALD-D accompanying on the tour. During interview, on February 13, 2024, at 1:00 p.m., ALD-D stated they understood the smoke alarm requirements and would figure out how to get them interconnected.	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 15 No further information was provided.	{0 780}			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 13, 2024, at 12:00 p.m., survey staff toured the facility with assisted living director	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
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0 790	Continued From page 16 (ALD)-D. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly and serviced annually by a certified technician or annually replaced with a new extinguisher. During interview, on February 13, 2024, at 1:00 p.m. survey staff explained to ALD-D that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. ALD-D verified the findings and stated that they understood the requirements. No further information was provided.	0 790			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{0 810}	Continued From page 17 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 18 or has potential to affect a large portion or all of the residents). The findings include: On February 13, 2024, the assisted living director (ALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, Sweep), but the policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{0 810}	Continued From page 19 procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on February 13, 2024, at 1:00 p.m., ALD-D stated they had not had an opportunity to update the policy to make it site specific and were working on developing the training first. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. ALD-D was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ALD-D was unable to provide documentation showing any training provided or training scheduled for a future date for staff since the date of the last survey. During an interview on February 13, 2024, at 1:00 p.m., ALD-D stated they were developing the training modules and working on getting all the staff their first training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ALD-D was unable to provide documentation showing any evacuation drills were completed or scheduled for a future date for staff since the date of the last survey.	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
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{0 810}	Continued From page 20 During an interview on February 13, 2024, at 1:00 p.m., ALD-D stated they had not completed any evacuation drills since the date of the last survey because they were focusing on developing the training method for their staff. No further information was provided.	{0 810}			
{0 820} SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
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{0 820}	Continued From page 21 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 13, 2024, from 12:00 p.m. to 1:00 p.m., survey staff toured the facility with assisted living director (ALD)-D. During the tour, survey staff asked ALD-D if they had replaced any of the windows in basement bedroom #4. ALD-D stated they had not replaced any windows yet. The noncompliant measurements were as follows: Occupied Sleeping Room: Bedroom #4 occupied by R1: two (2) windows, the first window measured 17 inches clear width, 38 inches clear height, and 646 square inches total open area each side. The second window measured 18 inches clear width, 38 inches clear height, and 684 square inches total open area each side. The windows in bedroom #4 did not meet the minimum requirements for opening width and the first window did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ALD-D that at least one window in each bedroom in a state-licensed	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 22 facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. ALD-D stated they were working with a contractor to get a cost estimate to replace the window. ALD-D provided a cost estimate dated January 23, 2024. Record review of the plan of correction from the initial survey completed on October 20, 2023, indicated the licensee planned to relocate R1 to a different bedroom while they worked on replacing the window with an egress-compliant window. R1 was still living in bedroom #4 at the time of this follow-up survey. During interview on February 13, 2024, at 1:00 p.m. ALD-D stated they could not convince R1 to temporarily move out of bedroom #4 as indicated on their approved plan of correction. ALD-D also stated they could not provide documentation of a fire watch policy or log showing the staff was performing a fire watch to protect R1 while they remained in bedroom #4 without a second means of egress. Survey staff reviewed the requirements for a fire watch with ALD-D and informed them that a fire watch must be maintained and documented until the window is corrected if they are unable to temporarily relocate R1. On February 13, 2024, survey staff explained to ALD-D that an immediate correction order was issued for the above finding. ALD-D acknowledged the above finding. No Further information was provided.	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01370}	Continued From page 23	{01370}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01370}	Continued From page 24 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on 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 one of three unlicensed personnel ((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) 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-J had a hire date of April 22, 2022. ULP-J's Unlicensed Personnel Competency Evaluation dated January 26, 2024, lacked evidence the following required trainings and competency evaluations were completed: - maintenance of a clean and safe environment; - hair care - care and use of hearing aids; and - dressing and assisting with toileting; - training on the prevention of falls; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology	{01370}			

Minnesota Department of Health

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{01370}	Continued From page 25 equipment and assistive devices. Additionally, the licensee failed to provide ULP-J with following competencies required per Minnesota Statute 144G.61 Subd (2)b: - 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 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. On February 14, 2024, at 11:58 a.m., licensed assisted living director (LALD)-D provided each ULP's employee record and stated if any required content was not included in the record, then the licensee had not completed the corrections from the previous survey. LALD-D stated licensee had not corrected all citations from the previously completed survey but were in the process of making corrections. The licensee's undated Competency Evaluations policy indicated all required content for licensee's training program and included all competency training lacking from ULP-J's record. No further information provided.	{01370}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 26 least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training for three of three direct care employees (unlicensed personnel (ULP)-B, ULP-F, 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) 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).	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01530}	Continued From page 27 The findings include: ULP-B ULP-B was hired by the licensee on May 28, 2021, under the comprehensive license and as of August 1, 2021, provided direct cares to assisted living residents. ULP-B's employee record did not include any dementia training. It lacked eight hours of initial training within 160 hours of the start date. ULP-B's employee record lacked required annual dementia training for 2022 and 2023. ULP-F ULP-F was hired by the licensee on May 25, 2021, under the comprehensive license and as of August 1, 2021, provided direct cares to assisted living residents. ULP-F's employee record included a Dementia Training Checklist, dated August 1, 2021. The checklist lacked completion dates for any of the training items listed. ULP-F's employee record lacked required annual dementia training for 2022 and 2023. ULP-J ULP-J was hired by the licensee on April 22, 2022. ULP-J's employee record did not include any dementia training. It lacked eight hours of initial training within 160 hours of the start date. ULP-J's employee record lacked required annual dementia training for 2023.	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01530}	Continued From page 28 On February 14, 2024, at 11:58 a.m., licensed assisted living director (LALD)-D provided each ULP's employee record and stated if any required content was not included in the record, then the licensee had not completed the corrections from the previous survey. LALD-D stated licensee had not corrected all citations from the previously completed survey but were in the process of making corrections. The licensee's undated Dementia Care Training policy indicated direct care staff must complete eight hours of initial dementia care training within 160 hours from employment and two hours annually ongoing. No further information provided.	{01530}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01650}	Continued From page 29 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an authenticated service plan included the required content for two of two residents (R1 and R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's Assisted Living Service Plan dated January 24, 2024, lacked the schedule and methods of monitoring staff providing services, a contingency	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/15/2024
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{01650}	Continued From page 30 plan that included the action to be taken if the scheduled service cannot be provided, and authentication by the resident or the resident's designated representative. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's Assisted Living Service Plan dated January 23, 2024, lacked the schedule and methods of monitoring staff providing services, a contingency plan that included the action to be taken if the scheduled service cannot be provided, and authentication by the resident or the resident's designated representative. On February 14, 2024, at 11:58 a.m., licensed assisted living director (LALD)-D provided each resident's record and stated if any required content was not included in the record, then the licensee had not completed the corrections from the previous survey. LALD-D stated licensee had not corrected all citations from the previously completed survey but were in the process of making corrections. The licensee's undated Service Plan policy indicated each resident would have an authenticated completed service plan in each respected resident's record with all required content. No further information provided.	{01650}			
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 31 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for two of two residents (R1 and R2). 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	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 32 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's Assisted Living Service Plan dated January 24, 2024, indicated R1 received the service, "Medication Reminder," daily. R1's Medication Management Services - Addendum to Service Plan dated January 24, 2024, indicated the licensee's staff conducted medication administration for R1 daily. R1's Medication Management Services - Addendum to Service Plan dated January 24, 2024, indicated the RN failed to assess all medications resident was taking were reviewed for side effects, contraindications, allergies, or adverse reactions. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's Assisted Living Service Plan dated January 23, 2024, indicated R2 received the service, "Medication Reminder," daily. R2's Medication Management Services - Addendum to Service Plan dated January 23,	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 33 2024, indicated the licensee's staff conducted medication administration for R2 daily. R2's Medication Management Services - Addendum to Service Plan dated January 23, 2024, indicated the RN failed to assess all medications resident was taking were reviewed for side effects, contraindications, allergies, or adverse reactions. On February 14, 2024, at 11:58 a.m., licensed assisted living director (LALD)-D provided each resident's record and stated if any required content was not included in the record, then the licensee had not completed the corrections from the previous survey. LALD-D stated licensee had not corrected all citations from the previously completed survey but were in the process of making corrections. The licensee's undated Medication Management Services policy indicated a registered nurse would assess each resident's medications for side effects, contraindications, allergies, or adverse reactions. No further information provided.	{01700}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 34 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the medication administration record (MAR) contained documentation of the reason and follow-up when a medication was not administered as prescribed, and failed to ensure medication administration was documented accurately to include the time of administration for two of two residents (R1, R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's Assisted Living Service Plan dated January 24, 2024, indicated R1 received the service, "Medication Reminder," daily.	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 35 R1's Medication Management Services - Addendum to Service Plan dated January 24, 2024, indicated the licensee's staff conducted medication administration for R1 daily. R1's record included multiple pages identified by licensed assisted living director (LALD)-D as R1's MAR. R1's MAR dated January 2024, lacked documentation of administration for multiple medications on January 17, 18, 19, 23, 25, 26, 30, and 31, for either the AM (morning) or HS (hour of sleep or bedtime). R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's Assisted Living Service Plan dated January 23, 2024, indicated R2 received the service, "Medication Reminder," daily. R2's Medication Management Services - Addendum to Service Plan dated January 23, 2024, indicated the licensee's staff conducted medication administration for R2 daily. R2's record included multiple pages identified by LALD-D as R2's MAR. R2's MAR dated January 2024, lacked documentation of administration for multiple medications on January 11, 25, 26, 27, 28, 29, 30, and 31, for either the AM (morning) or HS (hour of sleep or bedtime). On February 15, 2024, at 11:00 a.m., LALD-D stated clinical nurse supervisor (CNS)-E was not able to be contacted during the survey due to a family situation, but LALD-D asked CNS-E about the missing documentation. LALD-D stated CNS-E told them all medications should have	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 36 been documented as administered as ordered as CNS-E had not been contacted about any refusal or missed administrations. LALD-D stated staff assigned to work missing documentation shifts identified failed to document medications administration as required. The licensee's undated Documentation of Medication Administration policy indicated all staff would immediately document on each resident's MAR when medications were administered. The policy indicated if a refused or missed dose occurred, staff would immediately document the refusal or missed dose and contact the on-call nurse immediately. No further information provided.	{01760}			
{01830} SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of two residents (R1 and R2). 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	{01830}			

Minnesota Department of Health

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{01830}	Continued From page 37 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's Assisted Living Service Plan dated January 24, 2024, indicated R1 received the service, "Medication Reminder," daily. R1's Medication Management Services - Addendum to Service Plan dated January 24, 2024, indicated the licensee's staff conducted medication administration for R1 daily. R1's record included multiple pages identified by licensed assisted living director (LALD)-D as R1's medication administration record (MAR). R1's MAR dated January 2024, and February 2024, indicated R1 received medication administration of medications which required a current authenticated prescriber order. R1's record lacked current signed prescriber orders for all medications R1 received. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's Assisted Living Service Plan dated January 23, 2024, indicated R2 received the service, "Medication Reminder," daily.	{01830}			

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{01830}	Continued From page 38 R2's Medication Management Services - Addendum to Service Plan dated January 23, 2024, indicated the licensee's staff conducted medication administration for R2 daily. R2's record included multiple pages identified by licensed assisted living director (LALD)-D as R2's medication administration record (MAR). R2's MAR dated January 2024, and February 2024, indicated R2 received medication administration of medications which required a current authenticated prescriber order. R2's record lacked current signed prescriber orders for all medications R2 received. On February 14, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-E was on the phone with R2's primary care provider's (PCP) office. CNS-E stated licensee was seeking to get signed orders for R2's medications. CNS-E stated both R1 and R2 lacked current prescriber orders as both residents were establishing care with a new provider. CNS-E stated once both residents established care with new PCPs, orders would be obtained from the new PCPs. The licensee's undated Medication Prescriptions and Refills policy indicated the registered nurse would ensure all medications each resident was administered had a current and annually updated signed prescription. No further information provided.	{01830}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 5, 2023

Licensee

Elite Nursing Services, Inc.

3100 Thurber Road

Brooklyn Center, MN 55430

RE: Conditional License Number 414159
Health Facility Identification Number (HFID) 36036
Project Number(s) SL36036015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 20, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **March 4, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$6,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - \$3,000.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

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 MDH 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://www.web.health.state.mn.us/form/HRD-Appeals-Form>**.

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.

CONDITIONAL LICENSE ISSUED:

MDH will issue Elite Nursing Services, Inc. a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Elite Nursing Services, Inc. is in substantial compliance.

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

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. No new admissions:** Elite Nursing Services, Inc. will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Elite Nursing Services, Inc. must provide the Department:
 - i.** A list of the names and birthdates of any individuals Elite Nursing Services, Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

- ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Elite Nursing Services, Inc. will contract with an RN to provide consultation concerning all resident(s) to whom Elite Nursing Services, Inc. provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Elite Nursing Services, Inc.. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Elite Nursing Services, Inc. and MDH must review the RN's credentials and approve the selection. Elite Nursing Services, Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Elite Nursing Services, Inc. in an effort to help Elite Nursing Services, Inc. align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Elite Nursing Services, Inc. will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Elite Nursing Services, Inc. and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to

them;

- v. Overall impressions about the quality of the assisted living services delivered;
- vi. Overall impressions about the dignity with which the residents and their family members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Elite Nursing Services, Inc. to correct the violations cited during the survey as well as to determine the overall practice of Elite Nursing Services, Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

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

g. Corrective Action Plan: Elite Nursing Services, Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Elite Nursing Services, Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Elite Nursing Services, Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Elite Nursing Services, Inc.'s assisted living facility license, and Elite Nursing Services, Inc. will correct violations identified during the survey to come into substantial compliance. If MDH determines Elite Nursing Services, Inc. is not in substantial compliance, MDH may take additional enforcement action against Elite Nursing Services, Inc., including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary

suspension and revocation.

REQUESTING A HEARING:

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

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155
Health.HRD.Appeals@state.mn.us

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

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

Sincerely,

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

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36036015-0 On October 16, 2023, through October 20, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were two active residents; both of whom received services under the Assisted Living license. An immediate correction order was identified on October 16, 2023, issued for SL36036015-0, tag identification 0820. An immediate correction order was identified on October 19, 2023, issued for SL360036015-0, tag identification 0495. On October 20, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and implemented current policies and procedures. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 17, 2023, at 10:30 a.m., office manager (OM)-C stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Owner/Administrator (OA)-G on June 13, 2023. On October 19, 2023, at 10:32 a.m., OM-C stated OA-G had gone out of the country in July and would return sometime between now and the end of the year. While OA-G was out of the country, OM-C was the person in charge of all areas of the company. The licensee had an Assisted Living license issued on October 1, 2023, with an expiration date of September 30, 2024. On October 17, 2023, at 10:30 a.m., OM-C confirmed the three-ring binder in the home, Elite Nursing Services HWS (housing with services) Policies and Procedures Handbook, contained all the facility's policies. If a policy was not in the	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 binder or listed in the binder's table of contents, they did not have any additional policies elsewhere. The policies in the binder were specific to department of human services (DHS) licensure and lacked required policy or procedural information to maintain compliance with 144G statutes. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - staff orientation, training, and competency evaluations; - nursing assessments; - orientation to and implementation of the assisted living bill of rights; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On October 18, 2023, at 8:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they did not have any input on policy development and implementation. On October 19, 2023, at 2:35 p.m., OM-C stated they were not aware the policies and procedures present in the facility did not meet the compliance requirements of the assisted living licensure. OM-C had already initiated scheduling an appointment, planned for October 23, 2023, with a consultant for support with compliance. As a result of this survey, the following orders were issued 0250, 0430, 0460, 0470, 0480, 0485, 0490, 0495, 0510, 0580, 0630, 0650, 0660, 0680,	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 0720, 0730, 0770, 0780, 0810, 0820, 0900, 0950, 0970, 1370, 1440, 1460, 1500, 1530, 1610, 1620, 1650, 1700, 1710, 1730, 1760, 1770, 1800, 1810, 1830, 1880, 1890, 1900, 1910 and 2400. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services and	0 430			

Minnesota Department of Health

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0 430	Continued From page 8 amenities (UDALSA) with the required content for two of two residents (R1 and R2). In addition, the licensee failed to ensure the UDALSA accurately reflected services provided by the licensee. This had the potential to affect all residents and potential residents searching for appropriate assisted living placement. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: UDALSA PROVIDED TO RESIDENT R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R2's unsigned Home Health Aide Care Plan-Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. Records for R1 and R2 lacked evidence of a signature from the resident or resident representative indicating that a UDALSA had been provided to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted	0 430			

Minnesota Department of Health

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0 430	Continued From page 9 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, identifying all services allowed under the license that the facility does not provide; and -an oral explanation of the services offered under the contract. On October 18, 2023, at 9:00 a.m., office manager (OM)-C presented the surveyor with an unsigned copy of the licensee's UDALSA, dated September 18, 2023. On October 19, 2023, at 2:35 p.m., OM-C stated all the resident documents were provided to the surveyor and if something was not there, they did not have it. ACCURATE REFLECTION OF SERVICES The UDALSA, indicated on page two, a licensed registered nurse or licensed practical nurse would be on site at the facility twenty-four hours a day and seven days per week. On page twelve, the UDALSA indicated breakfast, lunch, and dinner were available in the community space. Page sixteen indicated facility units were semi-private and that there were kitchens in the units. Page seventeen indicated there to be washer-dryers in units. On October 18, 2023, at 2:15 p.m., via telephone interview, clinical nurse supervisor (CNS)-E, stated they were on-site at the facility approximately one hour each week. On October 18, 2023, at 2:17 p.m., OM-C stated there were no other nurses working for the facility. The hours worked by CNS-E were the only time a nurse was on site at the facility.	0 430			

Minnesota Department of Health

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0 430	Continued From page 10 Throughout observations on October 16, 17, 18, and 19, 2023, the surveyor observed R1 and R2 independently prepare their own food items throughout the days and at no particular or consistent times. No meals were prepared by staff and made available in the community space. On October 16, 2023, at 11:30 a.m., the surveyor toured the entire facility and observed all bedrooms to be private, there were no semi-private rooms on-site. None of the rooms had kitchens, washers, or dryers in unit. There was one kitchen on the main floor shared by all residents and one washer and dryer in the lower-level laundry room shared by all residents. Throughout observations on October 16, 17, 18, and 19, 2023, the surveyor observed the following services performed or documented in the facility but not noted as available on the UDALSA: clinical monitoring of labs related to medications, administration of intramuscular (IM) injections, and administration of inhalers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's	0 460			

Minnesota Department of Health

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0 460	Continued From page 11 visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs twenty-four hours a day, seven days a week. 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 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: R1 was admitted for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R2 was admitted and began receiving assisted living services on October 2, 2022.	0 460			

Minnesota Department of Health

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0 460	Continued From page 12 On October 16, 2023, at 11:30 a.m., the surveyor observed R2's room and did not see a call light or other means to summon staff. R2 was in the room seated in a recliner playing a game on his cellular telephone (cell phone). R2 stated if he needed staff, he would walk around the house to find them. R2 stated if he could not find someone, he would call unlicensed personnel (ULP)-B from his cell phone for help because he had their phone number. R2 stated ULP-B would help them find out who was working and get in touch with them, or ULP-B would come to the house herself because ULP-B lives close by. On October 17, 2023, at 10:30 a.m., office manager (OM)-C stated the facility did not have a call light or pendant system in place for residents to summon staff. OM-C stated residents would need to come out of their rooms to the common areas of the house if they needed to communicate with the staff. On October 18, 2023, at 10:45 a.m., OM-C brought a portable call button alert system to the facility as an option that would work for residents to alert staff if it were set up in resident rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 470	Continued From page 13 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more persons were available, in the same building, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs. In addition, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of four residents and had a current census of two residents. R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2	0 470		

Minnesota Department of Health

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0 470	Continued From page 15 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. STAFF AVAILABILITY During the entrance conference on October 17, 2023, at 10:30 a.m., office manager (OM)-C stated the facility was always staffed with one awake unlicensed personnel (ULP). On October 18, 2023, at 12:33 p.m., the surveyor observed R1 asking for ULP-F or OM-C to drive R1 to R1's girlfriend's house. R2 was upstairs in R2's bedroom with the door shut when R1 and ULP-F left the facility. ULP-F did not let R2 know he was leaving. OM-C was at the facility, but normally works from another location. ULP-F returned to the facility at approximately 2:45 p.m. R2 was in R2's room the entire time ULP-F was gone. On October 19, 2023, at 1:50 p.m., R2 stated they do sometimes come downstairs to find no one else in the facility. R2 stated the ULPs drive R1 places and sometimes tell R2 they are leaving, but not always. On October 19, 2023, at 4:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they were alright with residents being at home alone because the residents go out alone and don't require supervision. STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet	0 470		

Minnesota Department of Health

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0 470	Continued From page 16 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 - ensured 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. On October 18, 2023, at 11:50 a.m., OM- C stated they were not aware of a formal staffing plan or any discussion about appropriate staffing levels with nursing. On October 18, 2023, at 8:00 p.m., via telephone interview, CNS- E stated the licensee had not created a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480			

Minnesota Department of Health

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0 480	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 17, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and	0 485			

Minnesota Department of Health

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0 485	Continued From page 18 (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals were offered to the residents daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The licensee also failed to post a menu a week in advance and inform residents in advance of menu changes. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MENU POSTING On October 16, 2023, at 11:30 a.m., during a tour of the facility, the surveyor observed there was not a food menu posted in any part of the facility. On October 18, 2023, at 11:30 a.m., OM-C stated the facility does not have any planned or posted menus. MEAL PREPARATION AND SNACK AVAILABILITY On October 16, 2023, 3:00 p.m., unlicensed	0 485			

Minnesota Department of Health

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0 485	Continued From page 19 personnel (ULP)-B stated the residents of the facility make their own meals and snacks when they want to. ULP-B stated R2 would eat whatever was prepared for them, but R1 would not eat anything the staff prepared. ULP-B stated they are independent with cooking and will ask staff for help when needed. On October 17, 2023, at 10:30 a.m., during review of entrance conference information, office manager (OM)-C stated the facility provided three meals per day, served per Minnesota Food Code. OM-C stated the staff had prepared meals for residents in the past but R1 would not eat anything prepared by staff. OM-C stated both residents preferred to prepare their own food. On October 18, 2023, at 11:30 a.m., OM-C stated the facility does not have any planned menus. OM-C stated the facility has an account for Walmart that is accessible to the residents on a central computer. The residents add items to the Walmart grocery order, then the facility pays for and obtains the requested items. On October 19, 2023, at 4:00 p.m., via telephone interview, clinical nurse supervisor (CNS)- E stated the current facility residents were independent and could eat what they wanted to. When asked if specific items the residents had been observed eating the last few days were part of a nutritious meal plan, CNS-E stated they were not. OBSERVATIONS OF RESIDENT FOOD CHOICES AND PREPARATION While at the facility from October 16, 2023, until October 19, 2023, the surveyor did not observe staff prepare any meals or snacks for R1 or R2. The surveyor made the following observations	0 485			

Minnesota Department of Health

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0 485	Continued From page 20 about resident food choices and dietary intakes. On October 16, 2023, at 10:30 a.m., the surveyor observed R2 walk downstairs from their room to the kitchen. R2 prepared something in the microwave while watching their cell phone, and brought their food back up to their room. On October 16, 2023, at 12:33 p.m., the surveyor observed R2 in the kitchen. R2 removed five store bought chocolate chip cookies from a package in one of the cabinets. The surveyor asked R2 if staff cooked meals and prepared snacks for them. R2 stated, "they make stuff sometimes". On October 16, 2023, at 2:45 p.m., the surveyor observed R2 in the kitchen prepare a cup of noodles in the microwave for themselves and brought it upstairs to their room. On October 18, 2023, the surveyor observed R1 walk upstairs from their room. R1 prepared a large bowl of chocolate puffs cereal with milk, and ate the cereal in the kitchen. On October 19, 2023, at 1:50 p.m., the surveyor observed R2 in the kitchen prepare a cup of noodles in the microwave for themselves and brought it upstairs to their room. R2 stated they like making themselves something to eat when they are hungry. R2 stated they would ask staff if they wanted something more than what they could make on their own. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated September 18, 2023, indicated on page twelve, under Dining and Nutrition Services they would have the required three meals and snacks per	0 485			

Minnesota Department of Health

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0 485	Continued From page 21 day available. The UDALSA indicated they would have breakfast, lunch, and dinner available in the community space. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical,	0 490			

Minnesota Department of Health

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0 490	Continued From page 22 mental, and psychosocial needs, that create opportunities for active participation in the community at large. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, through October 19, 2023, the surveyor did not observe any activities planned or offered to the residents. The residents remained in their rooms most of the day. On October 16, 2023, at 11:30 a.m., during a tour of the facility, the surveyor observed there was not an activity calendar posted in any part of the facility. On October 17, 2023, at 10:30 a.m., during review of entrance conference information, office manager (OM)-C stated the residents were independent, and the facility did not provide a daily program of social and recreational activity. On October 18, 2023, at 8:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated the facility did not provide a daily program of social and recreational activity, however, staff will drive the residents' places and they take R2 to the gym for exercise.	0 490			

Minnesota Department of Health

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0 490	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure staff and residents had access to a registered nurse (RN) on-call for current and foreseeable needs 24 hours a day, seven days per week due to full time employment at another health care provider. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on October 19, 2023, at approximately 11:45 a.m. The findings include: On October 16, 2023, at 10:00 a.m., the surveyor entered the facility. Unlicensed personnel (ULP)-A stated the facility nurse had another job and came to the facility on Saturdays.	0 495	On October 20, 2023, the immediacy of correction order 0495 was removed, however non-compliance remained at a scope and level of I.	

Minnesota Department of Health

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0 495	Continued From page 24 On October 16, 2023, at 3:00 p.m., ULP-A stated they call the nurse when needed and leave them a message. ULP-A stated sometimes it takes longer for the nurse to respond but they were not sure how long any specific time had been. On October 16, 2023, at 5:25 p.m., the surveyor received an email from the office administrator (OA)-G. The email provided clinical nurse supervisor (CNS)-E's contact information and indicated CNS-E would be the contact person for questions related to the survey. On October 17, 2023, at 9:27 a.m., the surveyor attempted to reach CNS-E by phone. The phone went straight to voicemail. The surveyor left a message requesting a callback. On October 17, 2023, at 10:30 a.m., office manager (OM)-C stated staff contact the on-call registered nurse by calling them on their cell phone. OM-C did not provide a specific timeframe for expectations of a return call. OM-C stated CNS-E works at another job and sometimes takes longer to get back than others. OM-C verified CNS-E was the only registered nurse employed for the facility. On October 17, 2023, at 12:35 p.m., the surveyor sent an email to the email address provided for CNS-E and requested a confirmation response. On October 18, 2023, at 9:48 a.m., the surveyor attempted to reach CNS-E by phone. The call went straight to voicemail. On October 18, 2023, at 10:04 a.m., the surveyor requested ULP-F reach out to CNS-E as they would if they had an issue with a resident and	0 495			

Minnesota Department of Health

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0 495	Continued From page 25 needed support from nursing. On October 18, 2023, at 10:05 a.m., ULP-F called CNS-E from his personal cell phone. The surveyor heard him dial and CNS-E's voicemail played immediately. ULP-F left a message asking for a call back related to something at the facility. On October 18, 2023, at 12:45 p.m., OM-C stated they had received a text message from CNS-E and OM-C had requested them to call the surveyor. OM-C stated CNS-E was with a client at their other job and would call when they were able to talk. On October 18, 2023, at 2:02 p.m., the surveyor received a call from CNS-E. CNS-E stated they were available for phone discussion for approximately fifteen minutes before they were expected to arrive at their next home health client's home for an appointment. CNS-E stated they believed there was another nurse working as the as the CNS, but they were not sure who. In addition, CNS-E stated they were now a part-time quality nurse that "just does med set up and reviews vital signs once a week, nothing else". On October 18, 2023, at 2:45 p.m., ULP-F stated they had received a call back from CNS-E around 2:00 p.m. On October 18, 2023, at 7:55 p.m., the surveyor attempted to call CNS-E and the call went straight to voicemail. On October 28, 2023, at 7:57 p.m., the surveyor sent a text message to CNS-E requesting to meet by phone if they were available. On October 18, at 7:58 p.m., the surveyor	0 495		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 495	Continued From page 26 received a call from CNS-E. CNS-E stated they had worked full-time for licensee until July of 2021 when they started working at another full-time position. CNS-E stated they decreased their hours to "very part-time" for the licensee. CNS-E stated they work for a home health company Monday through Friday from 8:00 a.m., to 6:00 p.m. In addition, CNS-E stated they pick up extra hours at the home health job on the weekends, and their typical workday consisted of driving and going in and out of people's homes providing skilled nursing care. CNS-E stated the licensee's staff usually send them text messages when something is needed for the residents. CNS-E stated if a text comes through that is important, they prioritize it and return the message as soon as possible. CNS-E stated there are times when they are doing an admission or wound care with a client that they cannot stop what they are doing and answer the text. CNS-E stated if they were needed at the facility urgently during their other job, they might not be able to come to the facility. The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated September 18, 2023, indicated on page two, under the following, "Availability of Licensed (RN/LPN) Staff (in addition to an RN who is required to be accessible to the staff 24/7)", a licensed registered nurse or licensed practical nurse would be on site at facility twenty-four hours a day and seven days per week. In addition, page 15 indicated a Registered Nurse was on-site "part time". The licensee's undated Office Directory document indicated CNS-E was the Director of Nursing.	0 495			

Minnesota Department of Health

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0 495	Continued From page 27 On October 19, 2023, at 10:32 a.m., OM-C stated they were the person in charge of facility operations at this time. The facility had a new assisted living director in residency (ALD)-D. ALD-D had been involved in supporting the facility by providing staff direction related to cleaning, maintenance, and scheduling since May of 2023. OM-C stated in July 2023, ALD-D began the process to obtain their license for assisted living director and on October 17, 2023, ALD-D obtained their residency permit to begin working in the ALD capacity. OM-C stated they plan to involve ALD-D more in housing operations and begin transferring leadership to them soon. Currently, OM-C is the person in charge of facility operations. OM-C stated they were aware of the current assisted living requirements of statute 144G.41, and based on staff feedback and concerns CNS-E brought forward about resident issues, they had no indication that nursing was not meeting the needs of the facility. OM-C stated their expectation for time it would take the nurse to respond to a facility need was within five minutes. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 510	Continued From page 28 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B wash their hands, unlock the medication cabinet, remove the set-up medication box, open the box for that day, pour the box into R1's hand, then put the box back into the medication cabinet, lock the medication cabinet, and walk to the living room without washing their hands or using hand sanitizer after completing the task. On October 18, 2023, at 11:00 a.m., the surveyor observed ULP-F sitting in the living room, they	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 510	Continued From page 29 stood up and walked from the living room into the kitchen, got a glass from the cabinet, poured water from the refrigerator into the glass, unlocked the medication cabinet door, took the set up medication box out of the cabinet and set it on the counter, and got a small glass dish out of one of the kitchen cabinets. ULP-F poured the medications from the set up box into the glass cup, then handed the cup to R1. R1 took the medications and drank the water. ULP-F put the glass and bowl in the kitchen sink, then put the medication box back into the medication cabinet and locked the cabinet. ULP-F went back to sitting in the living room. They did not wash their hands or use hand sanitizer at any point before, during, or after the medication administration to R1. On October 17, 2023, at 11:30 a.m., ULP-B stated they received training about hand washing from clinical nurse supervisor (CNS)-E. ULP-B stated they should wash their hands before preparing meals, touching medications, or doing anything with the residents, and any time they feel or appear soiled. On October 18, 2023, at 8:00 p.m., via telephone interview, CNS-E stated they trained the ULPs on hand hygiene. CNS-E stated the ULPs were trained to wash hands or use hand sanitizer before and after every task they do and to wash their hands before handling food. On October 19, 2023, at 2:15 p.m., ULP-F stated they received training about hand washing from CNS-E. ULP-F stated they should wash their hands before every task they do with a resident or use hand sanitizer. Licensee's undated, Hand Washing policy	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 510	Continued From page 30 indicated proper hand washing was expected as part of the regular routine, even in the absence of recognized disease. In addition, the policy indicated hand washing must occur before and after medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management (QM) activities relevant to the facility size and services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
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0 580	Continued From page 31 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 October 18, 2023, at 8:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated licensee had not established nor implemented a quality management activity. CNS-E stated they were not aware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
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 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	0 630			

Minnesota Department of Health

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0 630	Continued From page 32 by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's record lacked an individual abuse prevention plan (IAPP) to include: - the person's susceptibility to abuse by another individual, including other vulnerable adults; - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On October 18, 2023, at 2:15 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated vulnerability assessments and IAPPs were	0 630			

Minnesota Department of Health

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0 630	Continued From page 33 done by the county case manager. CNS-E stated they did not participate in that process at all. The surveyor stated R1 had an IAPP in R1's record completed by CNS-E. CNS-E stated if it was with the assessment forms, they would have completed it, it was not something they usually did. The licensee's undated Individual Abuse Prevention Plan policy indicated an individual abuse prevention plan would be developed for each new resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 650	Continued From page 34 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 interview and record review, the licensee failed to ensure employee records contained the required content to include an annual performance evaluation for three of three employees (clinical nurse supervisor (CNS)-E, unlicensed personnel (ULP)-B, ULP-F). 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: CNS-E CNS-E began employment with the licensee on May 25, 2021, to provide oversight to unlicensed personnel and direct services to residents. CNS-E had worked for licensee in other areas of the company since 2009. CNS-E's employee record did not contain any performance evaluations. ULP-B ULP-B had a hire date of May 28, 2021.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 650	Continued From page 35 ULP-B's employee record did not contain any performance evaluations. ULP-F ULP-F had a hire date of May 25, 2021. ULP-F's employee record did not contain any performance evaluations. On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated performance reviews had not been completed in a formal procedure. There had been in person discussions of concerns but no written review or scheduled discussions of general performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 660	Continued From page 36 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included annual TB education, a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a completed health history for two of three employees clinical nurse supervisor (CNS)-E and unlicensed personnel (ULP)-F) and symptom screening for three of three employees (ULP-B, CNS-E, and ULP-F). In addition, the licensee failed to complete a facility TB risk assessment. 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 all residents, staff, and visitors of the facility). The findings include: TB Risk Assessment: On October 17, 2023, at 10:30 a.m., during the entrance conference with office manager (OM)-C, the surveyor requested the licensee's facility TB risk assessment. OM-C stated they were not aware of a TB risk assessment, and it would be CNS-E that would have completed one. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they had never	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 660	Continued From page 37 completed a TB risk assessment. Education/Symptom Screen/Testing: CNS-E CNS-E began employment with the licensee on May 25, 2021, to provide oversight to unlicensed personnel and direct services to residents. CNS-E's employee record lacked the following documentation: - annual TB education; - completed health history and symptom screening; and - baseline TB test screening via two-step TST or blood test. ULP-B ULP-B began employment with licensee on May 28, 2021, to provide direct cares to residents and was observed administering medications to residents on October 17, 2023. ULP-B's employee record lacked the following documentation: -completed health history and symptom screening; and -baseline TB test screening via two-step TST or blood test. ULP-F ULP-F began employment with licensee on May 25, 2021, to provide direct cares to residents and was observed administering medications to residents on October 18, 2023. ULP-F's employee record lacked the following documentation: - annual TB education; - completed health history and symptom screening; and	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 660	Continued From page 38 - baseline TB test screening via two-step TST or blood test. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated TB screening and testing should be completed upon hire. CNS-E was not aware of TB education requirements. CNS-E held the role of director of nursing for licensee. CNS-E stated she was only part-time and keeping track of employee education and needs was not something she had time to keep up with. The CDC Morbidity and Mortality Weekly Report (MMWR) Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH) dated June 2023, available on MDH's Frequently Asked Questions page indicated facilities should perform a facility risk assessment on an annual basis. The licensee's undated Tuberculosis Control policy, indicated the facility would complete an annual TB risk assessment. In addition, employees would receive baseline TB screening and testing upon hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 680	Continued From page 39	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 plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
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0 680	Continued From page 40 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 October 16, 2023, at 11:30 a.m., during a facility tour, the surveyor observed a posting titled, Emergency Preparedness Plan, which included procedures for medical emergency, power outage, fire, threat to violence, tornado, suspicious person, hazardous material, and emergency lock down. On October 17, 2023, at 10:30 a.m., office manager (OM)-C stated the facility emergency plan was posted on the wall in multiple locations, but they did not have an emergency preparedness manual. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - EPP reviewed and updated annually; - a description of the population served by the licensee; - quarterly review of missing resident policy; - communication plan containing all required elements; - hazard vulnerability assessment; - process for emergency plan collaboration; - subsistence needs for staff and residents; - procedures for tracking evacuated residents and staff; - policies for sheltering in place; - policies and procedures for medical documents;	0 680			

Minnesota Department of Health

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0 680	Continued From page 41 - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy and needs; - long term care family notifications; - emergency prep training program which includes maintain documentation of all EP training and EP training annually; and - emergency preparedness testing requirements. The licensee's undated Emergencies policy indicated the licensee would have individuals and staff trained in techniques to limit the potential for emergency situations and provided with the skills necessary to respond in an emergency situation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be 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 the appropriate records for residents and staff were readily available for	0 720			

Minnesota Department of Health

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0 720	Continued From page 42 timely access to 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: TIMELY ACCESS TO RECORDS: OCTOBER 16, 2023 - 8:45 a.m., the surveyor attempted to call the telephone number available to announce the survey. There was no answer, however, the surveyor was able to leave a voicemail message. - 9:09 a.m., the surveyor sent an email to facility email address of elitecare09@outlook.com, with information regarding the survey. The email requested the current resident roster, discharged resident roster, and employee list be ready for the surveyor upon arrival at the facility; indicated there would be an entrance conference to review expectations for the survey, and to have the registered nurse available at the time of survey. - 10:00 a.m., upon the surveyor's entrance to the facility, the only person on-site was unlicensed personnel (ULP)-A. ULP-A stated they had not heard from anyone at the office and were not aware of the surveyor's planned arrival. - 10:10 a.m., the surveyor attempted to reach the licensed assisted living director (LALD) by the	0 720			

Minnesota Department of Health

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0 720	Continued From page 43 telephone number listed for them on the posted Grievance procedure at the facility. The LALD's voicemail answered as a transportation company. The surveyor left a voicemail that they were looking for the person named as the LALD. - 10:20 a.m., ULP-A informed the surveyor they had reached office manager (OM)-C on their cell phone. ULP-A referred to OM-C as their supervisor. The surveyor talked with OM-C on ULP-A's cell phone and requested an email address for communication and clarification on who the LALD was. OM-C gave the surveyor owner administrator (OA)-G's email for communication, planning, and document requests. - 10:33 a.m., the surveyor sent an email to OA-G with survey information originally sent at 9:09 a.m. - 10:52 a.m., the surveyor forwarded the survey information email to the email address posted on Grievance Policy for the LALD. - 12:43 p.m., the surveyor emailed OA-G requesting response to proceed with survey communication. - 1:05 p.m., the surveyor observed another email address listed for OA-G on a contact information posting at the facility. The surveyor sent an email to this address and included the original email on file with the Minnesota Department of Health (MDH) of elitecare09@outlook.com, requesting response indicating who their contact person should be for questions, requesting documents, and handling immediate correction orders. - 3:00 p.m., ULP-B arrived at the facility for their	0 720			

Minnesota Department of Health

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0 720	Continued From page 44 shift. ULP-B stated the LALD was no longer with the company and gave the surveyor a cell phone number to reach clinical nurse supervisor (CNS)-E. - 4:00 p.m., the surveyor left the facility for the day. - 5:25 p.m., the surveyor received an email response from OA-G at the email address elitecare09@outlook.com, that stated CNS-E would be the point person and gave a phone number for them. - 7:43 p.m., the surveyor responded to the email from OA-G requesting clarification on who the LALD for the facility was as they needed communication on items in addition to what nursing could provide. OCTOBER 17, 2023 - 9:00 a.m., the surveyor entered the facility for the day. ULP-B was the only employee in the facility. - 10:00 a.m., OM-C arrived at the facility and provided current resident roster and employee roster. A discharge roster was not provided as OM-C did not recall having any additional discharged residents. After more discussion, it was determined there was one discharged resident. The previous emails sent by the surveyor also requested seven items for environmental engineering and the following items to be available to the surveyor for review: incident reports, Minnesota Adult Abuse Reporting Center (MAARC) reports, policy manual, tuberculosis program policies, copy of current bill of rights, and resident complaint form.	0 720			

Minnesota Department of Health

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0 720	Continued From page 45 - 10:14 a.m., the surveyor emailed a list of twenty documents needed to OM-C, CNS-E, and the company email. The requested documents included the previous requested documents not yet received, quality management program meeting minutes and activity plan, grievance procedure, marketing materials, blank uniform disclosure of assisted living services and amenities (UDALSA), contract, admission packet, list of licensed staff with evidence of licensure, complaints, staffing plan, current schedule for the week, and a list of all items needed from the current resident records. -10:30 a.m., assisted living director (ALD)-D arrived at the facility. The surveyor was able to proceed with entrance conference with OM-C and ALD-D in attendance. OM-C and ALD-D did not have responses to questions related specifically to nursing. - 11:30 a.m., OM-C and ALD-D left the facility to get requested records from the company office. - 1:15 p.m., ULP-F brought requested employee records, schedule for the week, and updated grievance postings with LALD removed. - 2:36 p.m., the surveyor emailed the company email and OM-C requesting documents missing from employee records upon review. - 3:30 p.m., the surveyor left the facility for the day. - 4:53 p.m., the surveyor received an email from OA-G that indicated licensee should be current with the surveyor's requests for all employee records the surveyor had found to be missing from the employee records reviewed earlier in the	0 720			

Minnesota Department of Health

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0 720	Continued From page 46 day. OA-G stated the licensee would provide the surveyor with the requested items from the records on October 18, 2023. OCTOBER 18, 2023 - 9:00 a.m., the surveyor arrived on site. UDALSA and marketing materials were left at the house for the surveyor. - 10:38 a.m., the MDH Assisted Living Physical Environment Evaluator emailed OM-C with additional request for documents initially requested upon survey initiation. - 12:59 p.m., the surveyor received the blank Client Grievance Complaint Form, by email from OM-C. - 1:47 p.m., the surveyor received the discharge summary for R3, by email from OM-C. OCTOBER 20, 2023 - 1:17 p.m., the surveyor received an email from OM-C that included a blank contract, initially requested on October 16, 2023. - 1:57 p.m., the surveyor sent the survey exit email to OM-C and the company email EliteCare09@outlook.com. COMMUNICATION WITH NURSING FOR ENTRANCE INFORMATION AND INTERVIEWS: OCTOBER 17, 2023 -9:27 a.m., the surveyor attempted to contact CNS-E by phone and left a voicemail. - 12:35 p.m., the surveyor sent an email to CNS-E requesting response. OCTOBER 18, 2023	0 720			

Minnesota Department of Health

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0 720	Continued From page 47 -9:48 a.m., the surveyor attempted to reach CNS-E by phone and left a voicemail. -12:45 p.m., OM-C received a text message from CNS-E indicating CNS-E was at their other home care job but would call the surveyor when they had time in between seeing clients. - 2:02 p.m., the surveyor received a call from CNS-E. CNS-E stated they only had fifteen minutes to talk. The surveyor reviewed part of the entrance conference nursing questions with CNS-E and made a plan to speak in the evening when CNS-E had more time available. - 7:55 p.m., the surveyor attempted to call CNS-E on their cell phone and left a voicemail. - 7:57 p.m., the surveyor sent a text message to CNS-E requesting a call back. - 7:58 p.m., the surveyor received a call back from CNS-E and was able to conduct a thorough interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 730			

Minnesota Department of Health

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0 730	Continued From page 48 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 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.	0 730			

Minnesota Department of Health

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0 730	Continued From page 49 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted and began receiving assisted living services on December 24, 2021. R3's diagnoses included bipolar type schizoaffective disorder, suicidal ideation, opiate addiction, chronic obstructive pulmonary disease (COPD), and atrial fibrillation. R3's records lacked a service plan. R3's progress notes dated December 24, 2021, entered by registered nurse (RN)-H, indicated facility would manage medications. RN-H's notes indicated collaboration with M Health Fairview for warfarin orders, Northwest Respiratory for oxygen, and Genoa Pharmacy for medication delivery. Ongoing documentation by RN-H and clinical nurse supervisor (CNS)-E indicated nurses had set up medications and unlicensed personnel (ULP) were administering medications throughout R3's time living at the facility.	0 730			

Minnesota Department of Health

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0 730	Continued From page 50 On March 24, 2022, licensee provided a termination of services notification to R3. The notice indicated R3 was being evicted due to continued self-neglect in the form of leaving the facility for days at a time without sharing his whereabouts. On April 24, 2022, the licensee terminated R3's assisted living services. On October 18, 2023, at 8:00 p.m., via telephone interview, CNS-E stated since they worked part-time for the licensee, they were not involved in the discharge process for R3. CNS-E stated they did not complete a discharge summary and was not aware it was needed. On October 17, 2023, at 10:30 a.m., OM-C confirmed the three-ring binder in the home, Elite Nursing Services HWS (housing with services) Policies and Procedures Handbook, contained all the facility's policies. If a policy was not in the binder or listed in the binder's table of contents, they did not have any additional policies elsewhere. The binder lacked policy or procedural information related to discharge process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic	0 770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 770	Continued From page 51 systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a space for outdoor activities for residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 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 residents). The findings include: On October 16, 2023, approximately from 12:30 p.m. to 1:00 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-A. During the facility tour, survey staff observed the outdoor space that would be used by residents was unsuitable for use by residents at the time of the survey. The yard was uneven and overgrown at	0 770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 770	Continued From page 52 the time of the survey and the only hard surface available to residents was the sidewalk along the side of the house from the back door. The driveway in front of the house was used full time to park staff and resident vehicles which did not allow for resident use. There was no seating area provided. ULP-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 780	Continued From page 53 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 16, 2023, approximately from 12:30 p.m. to 1:00 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-A. It was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by ULP-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810			

Minnesota Department of Health

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0 810	Continued From page 55 licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 16, 2023, approximately from 12:30 p.m. to 1:00 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-A. It was observed that there were no posted evacuation plans or diagrams in the facility. ULP-A visually verified this deficient finding at the time of discovery. A record review and interview were conducted on October 20, 2023, at approximately 11:30 a.m. with the assisted living director (ALD)-D and the office manager (OM)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency.	0 810			

Minnesota Department of Health

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0 810	Continued From page 56 During interview, ALD-D and OM-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ALD-D and OM-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, ALD-D and OM-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, ALD-D and OM-C stated the licensee did not have any documentation of staff training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the	0 810			

Minnesota Department of Health

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0 810	Continued From page 57 event of a fire including movement, evacuation, or relocation as required by statute. During interview, ALD-D and OM-C stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, ALD-D and OM-C verified that there were no documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not	0 820	This immediate correction order identified on October 16, 2023 has had the		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 820	Continued From page 58 constitute a distinct hazard to life. The licensee failed to provide resident bedroom #4 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedrooms #4 in the basement. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 16, 2023, approximately from 12:30 p.m. to 1:00 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-A. At approximately 12:45 p.m., survey staff asked ULP-A to open the first window in occupied resident bedroom #4 in the basement for measurement. ULP-A opened the window and measured the clear opening to be 38 inches in height and 17 inches in width with a total openable area of 646 square inches. Survey staff asked ULP-A to open the second window in occupied resident bedroom #4 in the basement for measurement. ULP-A opened the window and measured the clear opening to be 38 inches in height and 18 inches in width with a total openable area of 684 square inches. The windows do not meet the minimum requirements for opening width and window #1 does not meet the minimum requirements for total openable area. Survey staff explained to ULP-A that at least one	0 820	immediacy lifted as of October 20, 2023 by relocating the resident in occupied basement bedroom #4 to a different bedroom in the same facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 820	Continued From page 59 window in each bedroom in a state licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. ULP-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On October 16, 2023, at approximately 1:15 p.m., survey staff explained to ULP-A that an immediate correction order was issued for the above finding. ULP-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and	0 900			

Minnesota Department of Health

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0 900	Continued From page 60 (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility formerly held a Comprehensive Home Care license and converted to an Assisted Living license on August 1, 2021.	0 900			

Minnesota Department of Health

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0 900	Continued From page 61 R1 R1 was admitted for services under the comprehensive license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's record included a contract titled, "Rental Agreement," signed on May 19, 2021. R2 R2 was admitted and began receiving assisted living services on October 2, 2022. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's record included a contract titled, "Rental Agreement," signed on October 2, 2022. This contract document was the same version residents signed prior to the facility obtaining assisted living licensure on August 1, 2021. R1 and R2's records lacked a current assisted living contract signed prior to providing assisted living services with the required content including: - the health facility identification number of the facility (HFID); - the managing agent and/ or the authorized agent for the facility; - disclosure of the category of assisted living facility license held by the facility; - disclosure that the facility does not hold an	0 900			

Minnesota Department of Health

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0 900	Continued From page 62 assisted living facility with dementia care license; - other services available for an additional fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; - disclosure of the facility's ability to provide specialized diets; - a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints; - clear and conspicuous notice of the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; - contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: 1. whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; 2. whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); and 3. whether there is a limit on the number of people residing at the facility who can receive	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 900	Continued From page 63 customized living services or participate in the housing support program at any point in time. If so, the limit must be provided whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; -contact information to obtain long-term care consulting services under section 256B.0911; and -the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On October 20, 2023, at 1:17 p.m., the office manager (OM)-C provided the surveyor with a blank copy of the current contract that would be used if someone new moved in that day. The contract was titled Rental Agreement and had a noted revision date of August 2017. The contract was the same version signed by R1 and R2. OM-C stated licensee did not have any other contracts in place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 950	Continued From page 64	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for two of two residents (R1 and R2).	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 950	Continued From page 65 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Rental Agreement was signed on May 19, 2021. R1's record contained a document to designate a representative. R1 signed the document on August 1, 2021, and indicated that they wanted a representative. The form lacked identification of a designated representative and lacked any additional follow up of R1's wishes. R2 R2's Rental Agreement was signed on October 2, 2022. R2's contract lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated they were not aware the contract did not meet the requirements. Regarding R1's partially completed form, OM-C stated the person previously in the licensed assisted living director (LALD) position must have implemented the form but did not leave it in use when the LALD left the facility.	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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0 950	Continued From page 66 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R1 and R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee for services under the comprehensive home care license on	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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0 970	Continued From page 67 May 19, 2021, and began receiving assisted living services on August 1, 2021. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R1 and R2's assisted living contracts, included on page three, a section titled Your Responsibility. Item two indicated the resident was financially responsible for any damage in or to the building or resident room, including but not limited to carpet, walls, doors, light fixtures, bathroom fixtures or windows. Item eight on page four indicated the resident was responsible for costs accrued using emergency responders including medical, 911, police, fire department, etc. Page six, item seven, of the section titled Business Terms indicated if any legal action was required against the resident for any reason the resident would be responsible for all related expenses incurred by the licensee. On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated they were not aware the contract did not meet the requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01370	Continued From page 68 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01370			

Minnesota Department of Health

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01370	Continued From page 69 evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel ((ULP)-B and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 28, 2021, under the former comprehensive license and began providing assisted living services to licensee's residents on August 1, 2021. ULP-B's record lacked the following required trainings and competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including the care and use of hearing aids; - standby assistance techniques and how to perform them; - exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. On October 16, 2023, at 2:00 p.m., ULP-B stated they had worked for the company as a personal care assistant seeing clients in their own homes	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01370	Continued From page 70 prior to starting in this facility. ULP-B stated they received training at the office and out in the community from the nurse. ULP-F ULP-F was hired on May 25, 2021, under the comprehensive license and began providing assisted living services to licensee's residents on August 1, 2021. ULP-F's record lacked the following required trainings and competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including the care and use of hearing aids; and - standby assistance techniques and how to perform them. On October 18, 2023, at 2:45 p.m., ULP-F stated they had trained at the corporate office and at this facility. They recalled training with the nurse and with the licensed assisted living director but did not recall exactly what topics were covered. On October 18, 2023, at 8:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they had been responsible for training the ULPs when the facility opened in May of 2021. When asked about training and competency for hearing aide care and use and stand-by assist techniques, CNS-E stated it was not done. Regarding the other missing topics for ULP-B, CNS-E stated they must have missed doing them or checking them off but could not recall. The licensee's policy manual did not contain a policy for staff orientation, training, and competency evaluations that met the requirements of current licensure.	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01370	Continued From page 71 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two employee (unlicensed personnel (ULP)-B, ULP-F).	01440			

Minnesota Department of Health

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01440	Continued From page 72 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B had a hire date of May 28, 2021. On October 17, 2023, at 9:10 a.m., the surveyor observed ULP-B administer medication to R1. ULP-B's employee record lacked evidence a RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. ULP-F ULP-F had a hire date of May 25, 2021. On October 18, 2023, at 11:00 a.m., the surveyor observed ULP-F administer medication to R1. ULP-F's employee record lacked evidence a RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks. On October 18, 2023, at 2:15 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they train new ULPs when they start working with licensee. CNS-E stated they provide classroom training and hands on simulation competency at the office. Then CNS-E stated they provide training at the facility for one to two	01440			

Minnesota Department of Health

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01440	Continued From page 73 unlicensed personnel at a time. CNS-E stated they are always supervising ULPs when they are in the home but had not documented the supervision. CNS-E stated they did not know documentation of supervision was required. The licensee's policy manual did not contain a policy for supervision of unlicensed personnel that met the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure employees received orientation to the assisted living licensing requirements and regulations before providing direct care services for three of three employees (unlicensed personnel (ULP)-B, ULP-F, and clinical nurse supervisor (CNS)-E). This practice resulted in a level two violation (a	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01460	Continued From page 74 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 all residents, staff, and visitors of the facility). The findings include: ULP-B ULP-B had a hire date of May 28, 2021. On October 17, 2023, at 9:10 a.m., the surveyor observed ULP-B administer oral medications to R1. ULP-B's employee record lacked evidence of completing orientation to assisted living facility licensing requirements and regulations. ULP-F ULP-F had a hire date of May 25, 2021. On October 18, 2023, at 11:00 a.m., the surveyor observed ULP-F administer medication to R1. ULP-F's employee record contained an Orientation and Training Checklist dated August 1, 2021. The form was signed by ULP-F and the previous LALD, however, the date orientation/ training completed column was blank for all items listed. CNS-E CNS-E had a hire date of May 25, 2021. CNS-E's employee record lacked evidence of completing orientation to assisted living facility licensing requirements and regulations.	01460			

Minnesota Department of Health

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01460	Continued From page 75 On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated the previous licensed assisted living director (LALD), who was no longer with the company, handled training on assisted living facility licensing requirements and regulations. OM-C referred to the orientation checklist in ULP-F's employee record and stated they thought the training had been done as a group by the LALD and CNS-E in August of 2021. OM-C stated they believe ULP-B was trained but had no record of ULP-B or CNS-E receiving the required training. On October 18, 2023, at 2:45 p.m., ULP-F stated they did not recall a training at the office with previous LALD. In addition, ULP-F did not recall receiving an orientation to assisted living facility licensing requirements and regulations. On October 18, 2023, at 8:00 p.m., via telephone interview, CNS-E stated they participated in orientation for facility staff in August of 2021 but did not receive the training or watch the videos staff were required to. The licensee's undated Individual Orientation policy did not meet the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01500	Continued From page 76 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01500	Continued From page 77 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each twelve months of employment for three of three employees (clinical nurse supervisor (CNS)-E, unlicensed personnel ULP-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 29, 2021, to provide direct services to the residents.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01500	Continued From page 78 ULP-B's employee record contained no training records for annual training the years of 2021, 2022, or 2023. ULP-F ULP-F was hired on May 25, 2021, to provide direct services to the residents. ULP-F's employee record contained no training records for annual training the years of 2021, 2022, or 2023. CNS-E CNS-E began employment with the licensee on May 25, 2021, to provide oversight to unlicensed personnel and direct services to residents. CNS-E had worked for licensee in other areas of the company since 2009. CNS-E's employee record contained no training records for annual training the years of 2021, 2022, or 2023. On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated in the years before COVID, CNS-E would put together annual training at the start of the year, and everyone would receive the training. OM-C stated annual training was not something that had been resumed yet since the impact of COVID, there has been no formal annual training on the required topics since prior to August 1, 2021. The licensee's policy manual did not contain a policy for annual training that met the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01500	Continued From page 79 (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training for three of three direct care employees (clinical nurse supervisor (CNS)-E, unlicensed personnel	01530			

Minnesota Department of Health

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01530	Continued From page 80 (ULP)-B, and ULP-F). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for three of three direct care employees (CNS-E, ULP-B, and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-E CNS-E began employment with the licensee on May 25, 2021, to provide oversight to unlicensed personnel and direct care to residents. CNS-E had worked for licensee in other areas of the company since 2009. CNS-E's employee record did not include any dementia training. It lacked eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents, which was August 1, 2021. CNS-E's employee record lacked required annual dementia training for 2022 and 2023. ULP-B ULP-B was hired by the licensee on May 28, 2021, under the comprehensive license and as of August 1, 2021, provided direct cares to assisted living residents. ULP-B's employee record did not include any	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01530	Continued From page 81 dementia training. It lacked eight hours of initial training within 160 hours of the start date for providing direct care to assisted living residents, which was August 1, 2021. ULP-B's employee record lacked required annual dementia training for 2022 and 2023. ULP-F ULP-F was hired by the licensee on May 25, 2021, under the comprehensive license and as of August 1, 2021, provided direct cares to assisted living residents. ULP-F's employee record included a Dementia Training Checklist, dated August 1, 2021. The checklist lacked completion dates for any of the training items listed. On October 18, 2023, at 2:45 p.m., ULP-F stated they did not recall anything specific about dementia included in their training. ULP-F's employee record lacked required annual dementia training for 2022 and 2023. On October 18, 2023, at 11:30 a.m., office manager (OM)-C stated no annual training had been completed by any of their staff which included annual dementia care training. OM-C stated responsibility for employee training was shared by CNS-E and the former licensed assisted living director (LALD). OM-C stated the previous LALD left their position around April or May of 2023 and the new LALD was in training. The licensee's policy manual did not contain a policy for dementia training that met the requirements of current licensure.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01530	Continued From page 82 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment using the uniform assessment tool, as required by Minnesota Administrative Rule 4659.0140 Subpart 2, on or before the admission date for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01610			

Minnesota Department of Health

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01610	Continued From page 83 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's Rental Agreement assisted living contract was signed on October 2, 2022. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's record contained an undated, unsigned, Client Intake Report. The report contained demographic information, diagnoses, allergies, code status, bowel and bladder assessment, dietary needs, equipment needs, and a determination that R2 requires "med and disease management". R2's record lacked evidence of a comprehensive nursing assessment, that included all components of the uniform assessment tool, by a registered nurse (RN) of the physical and cognitive needs of R2 conducted prior to the date R2 moved into the facility and signed the assisted living contract. R2's record lacked the following components of the uniform assessment tool:	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01610	Continued From page 84 -personal lifestyle preferences, including sleep schedule, social needs, leisure activities, cultural preferences, and any other customary routine that is important to the resident's quality of life; -activities of daily living, including dressing, grooming, bathing, personal hygiene; mobility, ambulation, transfers, dental status, and oral care; -instrumental activities of daily living, including ability to self-manage medications; housework, laundry, and transportation; - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: 1. the reason taken; 2. any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; 3. the dosage; 4. the frequency of use; 5. the route administered or taken; 6. any difficulties the resident faces in taking the medication; 7. whether the resident self-administers the medication; 8. the resident's preferences in how to take medication; 9. interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and 10. provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; - a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations,	01610			

Minnesota Department of Health

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01610	Continued From page 85 surgeries, and care from a post-acute care facility; - a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; - weight; - initial vital signs if indicated by health conditions or medications; - emotional and mental health conditions, including review of history, current symptoms, behavioral concerns, and effective medication treatment and nonmedication interventions of any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders; - cognition, including a review of any neurocognitive evaluations and diagnoses; current memory, orientation, confusion, decision-making status and ability; - communication and sensory capabilities, including hearing, vision, speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood; - pain including location, frequency, intensity, and duration, and effectiveness of medication and nonmedication alternatives; - skin conditions; - risk indicators including 1. risk for falls including history of falls; 2. emergency evacuation ability; 3. complex medication regimen; 4. risk for dehydration, including history of urinary tract infections and current fluid intake pattern; 5. risk for emotional or psychological distress due to personal losses; 6. unsuccessful prior placements; 7. elopement risk including history or previous elopements;	01610			

Minnesota Department of Health

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01610	Continued From page 86 8. smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and 9. alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; - who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and the scope of decision-making authority of a substitute decision maker under subitem (1); and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they had completed an admission assessment R2. CNS-E stated the assessment was completed on the day the resident moved into the facility. CNS-E stated the initial assessment consisted of getting the information for the Client Intake Report, taking vital signs, going through medications, and setting up the medications for staff to administer. When asked if all items on the Uniform Assessment Tool were reviewed during the initial assessment, CNS-E stated no, they were not. On October 19, 2023, at 3:30 p.m., office manager (OM)-C stated the Client Intake Form was what they viewed to be the nursing assessment. The licensee's undated Admission policy and Admission Criteria policies indicated eligibility for admission would be evaluated based on individual needs and licensee's capacity to deliver services. The policies lacked mention of the responsibilities of the registered nurse.	01610			

Minnesota Department of Health

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01610	Continued From page 87 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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 licensee failed to ensure the registered nurse (RN) conducted nursing assessments no more than fourteen calendar days after initiation of	01620		

Minnesota Department of Health

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01620	Continued From page 88 services and/or ongoing nursing assessments not to exceed every ninety calendar days for two of two residents (R1, R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's record lacked the presence of any ongoing nursing assessments. R1's only assessment completed by a RN was conducted upon admission, May 19, 2021. That assessment did not contain all areas of the Uniform Assessment Tool as required by Minnesota Administrative Rule 4659.0140 Subpart 2. R1's admission assessment lacked the following components of the uniform assessment tool:	01620		

Minnesota Department of Health

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01620	Continued From page 89 - the resident's personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, spiritual preferences, cultural preferences, and any other customary routine that is important to the resident's quality of life; - advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; - activities of daily living, including toileting pattern, bowel and bladder control, dressing, grooming, bathing, personal hygiene, mobility, ambulation, transfers, assistive devices, eating, dental status, oral care, and assistive devices and dentures, if applicable; -instrumental activities of daily living, including ability to self-manage medications, housework, laundry, and transportation; - a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; - a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; - weight; and - initial vital signs if indicated by health conditions or medications; - cognition, including a review of any neurocognitive evaluations and diagnoses; current memory, orientation, confusion, decision-making status and ability; - communication and sensory capabilities, including hearing, vision, speech, assistive communication and sensory devices including	01620			

Minnesota Department of Health

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01620	Continued From page 90 hearing aids, and the ability to understand and be understood; - pain including location, frequency, intensity, and duration, and effectiveness of medication and nonmedication alternatives; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators, including: 1. risk for falls including history of falls; 2. emergency evacuation ability; 3. complex medication regimen; 4. risk for dehydration, including history of urinary tract infections and current fluid intake pattern; 5. risk for emotional or psychological distress due to personal losses; 6. unsuccessful prior placements; 7. elopement risk including history or previous elopements; 8. smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and 9. alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; - who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and the scope of decision-making authority of a substitute decision maker under subitem (1); and - the need for follow-up referrals for additional medical or cognitive care by health professionals. A review of prescription, over the counter, and supplemental medications was completed at the time of the admission assessment but lacked the	01620			

Minnesota Department of Health

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01620	Continued From page 91 following required components: 1. the reason each medication was taken; 2. any side effects, contraindications, and actions to address these issues; 3. any difficulties the resident faces in taking the medication; 4. whether the resident self-administers the medication; 5. the resident's preferences in how to take medication; 6. interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and 7. provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; At the time of survey conclusion on October 20, 2023, it was 884 days since R1's last nursing assessment. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's record lacked a fourteen-day assessment completed on or before October 16, 2022. R2's	01620		

Minnesota Department of Health

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01620	Continued From page 92 record lacked the presence of any ongoing nursing assessments. R2's only assessment completed by a RN was conducted upon admission, October 2, 2022. That assessment did not contain all areas of the Uniform Assessment Tool as required by Minnesota Administrative Rule 4659.0140 Subpart 2. R2's admission assessment lacked the following componenets of the uniform assessment tool: -personal lifestyle preferences, including sleep schedule, social needs, leisure activities, cultural preferences, and any other customary routine that is important to the resident's quality of life; -activities of daily living, including dressing, grooming, bathing, personal hygiene; mobility, ambulation, transfers, dental status, and oral care; -instrumental activities of daily living, including ability to self-manage medications; housework, laundry, and transportation; - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: 1. the reason taken; 2. any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; 3. the dosage; 4. the frequency of use; 5. the route administered or taken; 6. any difficulties the resident faces in taking the medication; 7. whether the resident self-administers the medication; 8. the resident's preferences in how to take medication; 9. interventions needed in management of medications to prevent diversion of medication by	01620			

Minnesota Department of Health

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01620	Continued From page 93 the resident or others who may have access to the medications; and 10. provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; - a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; - a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; - weight; - initial vital signs if indicated by health conditions or medications; - emotional and mental health conditions, including review of history, current symptoms, behavioral concerns, and effective medication treatment and nonmedication interventions of any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders; - cognition, including a review of any neurocognitive evaluations and diagnoses; current memory, orientation, confusion, decision-making status and ability; - communication and sensory capabilities, including hearing, vision, speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood; - pain including location, frequency, intensity, and duration, and effectiveness of medication and nonmedication alternatives; - skin conditions; - risk indicators including	01620			

Minnesota Department of Health

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01620	Continued From page 94 1. risk for falls including history of falls; 2. emergency evacuation ability; 3. complex medication regimen; 4. risk for dehydration, including history of urinary tract infections and current fluid intake pattern; 5. risk for emotional or psychological distress due to personal losses; 6. unsuccessful prior placements; 7. elopement risk including history or previous elopements; 8. smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and 9. alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; - who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and the scope of decision-making authority of a substitute decision maker under subitem (1); and - the need for follow-up referrals for additional medical or cognitive care by health professionals. At the time of survey conclusion on October 20, 2023, it was 383 days since R2's last nursing assessment. On October 18, 2023, at 2:15 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they completed initial assessments for R1 and R2 when they moved into the facility. CNS-E stated they have not performed any assessments since then for R1 and R2. CNS-E stated they work with licensee approximately one hour per week, and they only have time to set up medications and review documentation. CNS-E stated they do not do anything else for the licensee since they decreased their hours in July	01620			

Minnesota Department of Health

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01620	Continued From page 95 of 2021. CNS-E stated they thought there was another nurse working at the house doing things like assessments. CNS-E stated they had not seen any assessments in the records or collaborated with another RN, but still believed the assessments were being done. On October 19, 2023, at 10:32 a.m., office manager (OM)-C stated they were not aware CNS-E had not completed required assessments during CNS-E's working hours. OM-C stated CNS-E currently held the director of nursing position and was responsible for all required nursing responsibilities of the facility. The licensee's policy manual did not contain a policy for nursing assessments that met the requirements of current licensure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
01650	Continued From page 96 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content and all services to be provided for two of two residents (R1 and R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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01650	Continued From page 97 May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's diagnoses included schizophrenia and depression. SERVICE PLAN REQUIRED CONTENT R1 R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. However, it lacked: - the identification of staff or categories of staff who would provide services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that included the action to be taken if the scheduled service cannot be provided; - information identifying who had the authority to sign for the resident in an emergency; and - identification of any emergency circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C. R2 R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management.	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01650	Continued From page 98 However, it lacked: - the identification of staff or categories of staff who would provide services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that included the action to be taken if the scheduled service cannot be provided; - information identifying who had the authority to sign for the resident in an emergency; and - identification of any emergency circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C. On October 19, 2023, at 3:30 p.m., office manager (OM)-C stated the service plan was lacking the required information. OM-C stated the facility would work with a consulting service to update the service plan with the required information. OM-C stated they had an appointment scheduled with a consulting service for Monday, October 23, 2023. INCLUSION OF ACCURATE SERVICES PROVIDED On October 16, 2023, at 11:00 a.m., the surveyor observed medication boxes with set up medications for R1 and R2 in the facility's locked medication cabinet. On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B remove the medication box from locked medication cabinet, remove medications from set up strip, put the medications in a cup, hand the cup to R1, and R1 took the medications.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01650	Continued From page 99 On October 18, 2023, at 2:15 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they had provided medication set up for R1 and R2 since start of care for each resident. In addition, CNS-E stated the facility ULP provided medication administration of the medications, and CNS-E set up and any necessary as needed medications for R1 and R2. The service plans for R1 and R2 indicated both received medication reminders but, lacked information about medication set up by the nurse or medication administration by ULPs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 100 diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 16, 2023, at 11:00 a.m., the surveyor observed medication boxes with set up medications for R1 and R2 in the facility's locked medication cabinet. During the entrance conference on October 17, 2023, at 10:30 a.m., in the absence of the registered nurse, office manager (OM)-C confirmed the licensee provided medication management services to the licensee's residents.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01700	Continued From page 101 The current resident roster provided during the entrance conference indicated two of two residents received medication management services. On October 18, 2023, at 2:15 p.m., via telephone interview, Clinical Nurse Supervisor (CNS)-E stated they set up the medications for R1 and R2 every week on Saturday. CNS-E stated they were at the facility on October 14, 2023, and set up the medications currently in the medication boxes. R1 R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer propranolol 20 milligram (mg) tablet and Vitamin D3 1000 international units (IU) one capsule to R1 from a pill box set up by CNS-E. R2 R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. FACE TO FACE MEDICATION ASSESSMENT R1 and R2's records lacked evidence the RN had conducted a face-to-face assessment/review	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01700	Continued From page 102 that included an identification and review of all medications the resident is known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they review medications and talk to staff about what they are for but did not have the review documented. CNS-E verified R1 and R2's records lacked an individualized medication assessment to include the content listed above. MEDICATION INDICATIONS R1's medication administration record (MAR) lacked indications for all scheduled medications being administered by ULPs. In addition, the MAR included the medication benztropine tablets 0.5 mg once daily as needed. The MAR lacked an indication for the reason benztropine could be needed for R1. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E, stated R1 takes benztropine for Tardive Dyskinesia symptoms. "If he needs it, he will ask for it". (Tardive dyskinesia (TD) is a movement disorder characterized by uncontrollable, abnormal, and repetitive movements of the face, torso, and/or other body parts.) CNS-E agreed staff might recognize symptoms before R1 realizes R1 is having symptoms. R2's MAR lacked indications for all scheduled medications being administered by ULPs. SELF-MEDICATION WITH LACK OF ASSESSMENT R1'S MAR, dated October 2023, indicated R1	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01700	Continued From page 103 was prescribed sildenafil 20 mg tablets, with direction to take two to four tablets totaling 40 to 80mg by mouth thirty minutes before sexual activity once daily. On October 16, 2023, at 11:00 a.m., the surveyor observed that R1's record lacked a self-medication assessment. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated R1 keeps one bottle of sildenafil on his person and uses it when he needs it. R1 lets staff know when R1 needs a new bottle, they give R1 the bottle in the medication cabinet, and order a new one for the next time R1 asks for it. CNS-E stated there is no tracking of how often the bottles are given to R1 and CNS-E has not discussed R1's sildenafil with R1. CNS-E stated they have not completed a self-medication assessment with R1. CNS-E stated, "he has always kept that med". The licensee's policy manual did not contain a policy for medication management that met the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reassessment The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
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01710	Continued From page 104 minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for two of two residents (R1, R2). 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 October 16, 2023, at 11:00 a.m., the surveyor observed medication boxes with set up medications for R1 and R2 in the facility's locked medication cabinet. R1 R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's medication administration record (MAR) dated October, 2023, indicated R1 was receiving Vitamin D3 25 micrograms (mcg) one daily, olanzapine 10 milligrams (mg) once daily at	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01710	Continued From page 105 bedtime, propranolol 20 mg tablets three times daily, fluphenazine decanoate injection 25 mg/ milliliter (ml) one ml injected every two weeks, dermaphor ointment applied topically twice daily as needed, ibuprofen 400 mg tablets one tablet every six hours as needed for pain, melatonin 5mg capsules one capsule at bedtime as needed for sleep, sildenafil 20 mg tablets two to four tablets before sexual activity once daily, benztropine 0.5 mg tablets one tablet once daily as needed. On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer propranolol 20 milligram (mg) tablet and Vitamin D3 1000 international units (IU) one capsule to R1 from a pill box set up by clinical nurse supervisor (CNS)-E. R2 R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's medication administration record (MAR) dated October 2023, indicated R2 was receiving famotidine 20 mg one tablet twice daily, benztropine 1mg one tablet twice daily, haloperidol 10 mg two tablets at bedtime, omeprazole 20mg one capsule at bedtime, and diphenhydramine 25 mg one capsule as needed for insomnia. R1 and R2's records lacked monitoring and reassessment of medication management	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01710	Continued From page 106 services at least annually for the following: - documentation the assessment was conducted face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and - identification of interventions needed in management of medications. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they had provided medication set up for R1 and R2 since start of care for each resident. In addition, CNS-E stated the facility ULP provided medication administration of the medications, and CNS-E set up and any necessary as needed medications for R1 and R2. CNS-E stated they review medications and talk to staff about what they are for but did not have it documented. CNS-E verified R1 and R2's records lacked monitoring and reassessment of medication management services annually as required for the above content. The licensee's policy manual did not contain a policy for medication management that met the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01730	Continued From page 107 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, 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.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01730	Continued From page 108 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content two of two residents (R1,R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's medication administration record (MAR) dated October 2023, indicated R1 was receiving Vitamin D3 25 micrograms (mcg) one daily, olanzapine 10 milligrams (mg) once daily at bedtime, propranolol 20 mg tablets three times	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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01730	Continued From page 109 daily, fluphenazine decanoate injection 25 mg/ milliliter (ml) one ml injected every two weeks, dermaphor ointment applied topically twice daily as needed, ibuprofen 400 mg tablets one tablet every six hours as needed for pain, melatonin 5mg capsules one capsule at bedtime as needed for sleep, sildenafil 20 mg tablets two to four tablets before sexual activity once daily, benztropine 0.5 mg tablets one tablet once daily as needed. On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's MAR dated October 2023, indicated R2 was receiving famotidine 20 mg one tablet twice daily, benztropine 1mg one tablet twice daily, haloperidol 10 mg two tablets at bedtime, omeprazole 20mg one capsule at bedtime, and diphenhydramine 25 mg one capsule as needed for insomnia. R1 and R2's records lacked medication management plans, completed prior to initiation of services, including the following:	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01730	Continued From page 110 -a statement describing the medication management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they had provided medication set up for R1 and R2 since start of care for each resident. In addition, CNS-E stated the facility ULP provided medication administration of the medications, and CNS-E set up and any necessary as needed medications for R1 and R2. CNS-E stated they do talk with staff about resident medications, what they are for, what they do, and any specific information they need to know but CNS-E did not have those things documented. CNS-E verified R1 and R2's records lacked individualized medication management plans. The licensee's policy manual did not contain a	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01730	Continued From page 111 policy for medication management that met the requirements of current licensure. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed; failed to ensure the medication administration record (MAR) contained documentation of the reason and follow-up when medication was not administered as prescribed, and failed to ensure medication administration was documented accurately to include the time of administration for two of two residents (R1, R2). In addition, the licensee failed to ensure all prescribed medications were	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 112 maintained as available in the facility medication supply for use as needed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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). R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R2 R2 was admitted to the licensee and began receiving assisted living services on October 2, 2022. R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 113 appointments, and mental health management. MEDICATION ADMINISTRATION ULP-B On October 16, 2023, at 3:00 p.m., unlicensed personnel (ULP)-B stated they were trained to pass medications by clinical nurse supervisor (CNS)-E. ULP-B stated during that training, they were taught to look at the MAR to make sure they have the correct medications in the pill box, and they are giving them at the correct times. ULP-B stated they also learned there were rights to medication passing but did not remember how many. ULP-B stated the rights they remembered were the right person and right medication. On October 17, 2023, at 9:10 a.m., the surveyor observed ULP-B remove the set-up medication box from the medication cabinet, open the Tuesday morning compartment and pour the medications from the box into R1's hand. R1 then took the medications and drank a glass of water. ULP-B did not look at the MAR before or after giving the medications to R1. ULP-B did not perform three checks between the MAR and the set-up pills to ensure they had the correct medications. ULP-B did not document administration in the MAR. ULP-F On October 18, 2023, at 11:00 a.m., the surveyor observed ULP-F prepare morning medications for R1 by removing the set-up medications from the weekly pill box and putting them into a small dish. ULP-B then handed the dish and a glass of water to R1 in the kitchen. R1 took the medications, drank the water, and put the dish in the sink. ULP-F put the set-up pill box away in the medication cabinet. ULP-F did not perform three checks between the MAR and set-up pills to	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 114 ensure they had the correct medications. ULP-F did not document in the MAR. ULP-F stated they did not look at the MAR because the nurse set up what should be given. ULP-F stated they were trained by CNS-E, and if they were administering medications the nurse had not set up, they would look at the MAR. ULP-F stated they remembered the five rights of medication administration from training but did not list them all. They listed right person, medication, and dose. ULP-F did not recall checking the medication or label against the MAR more than one time. On October 18, 2023, at 2:45 p.m., the surveyor observed ULP-F remove the MAR from the medication cabinet and document his initials for the medication pass that was completed at 11:00 a.m. ULP-F stated they usually document everything at the end of their shift. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they trained the ULPs on medication administration and trained one or two ULPs at a time when the facility opened in May of 2021. CNS-E stated they provided some of the training at the office including classroom instruction, practicing with fake medications, and competency on items not present in the facility. CNS-E stated they trained on all routes of medication and used a competency form that they believed should be at the office. CNS-E stated they trained on unplanned time away, indication, side-effects, things to watch for specific to the facility. CNS-E stated they trained ULPs to check the MAR against the medication label or set up pill box at least two times to make sure they were giving the correct medication. CNS-E stated they did train on the rights of medication administration but did not recall how many, it might have been five, six, or seven.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 115 CNS-E listed medication, resident, dose, route, and documentation. MISSED MEDICATION DOSES AND LACK OF FOLLOW-UP DOCUMENTATION On October 16, 2023, at 2:00 p.m., the surveyor observed R1's medication box for the day still contained medications scheduled for AM that were typically given by 9:00 a.m. ULP-A stated R1 went out with their girlfriend last night at 10:15 p.m., and had not come home yet. On October 19, 2023, at 4:00 p.m., the surveyor observed R1's medication box still contained AM medications, including Vitamin D3 1000 international units (IU) one 25 microgram (mcg) capsule and propranolol 20 milligram (mg) tablet, for Sunday, Monday, and Tuesday; afternoon medications including propranolol 20 mg tablet, for Sunday, Monday, and Tuesday; and evening medications, including one olanzapine 10 mg tablet and one propranolol 20 mg, for Monday. The MAR was not filled out for any of the medications. There were no staff initials or other documentation in the corresponding date and time graph square and no additional documentation on the back of the MAR regarding the missed medication doses of medications. On October 16, 2023, at 1:47 p.m., ULP-A stated if a medication were not given, they would still initial it, circle their initials to indicate it was not given, and document why on the back of the MAR. If a resident missed a medication pass time, ULP-A stated they would administer the medications when the resident got home. If it were multiple medication passes that were missed, ULP-A stated they would call the nurse for direction.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 116 On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated when a medication is missed staff should circle their initials on the front of the MAR and make a notation of why the medication was missed on the back of the MAR. CNS-E stated they did not consider leftover medications in the box at the end of the week medication errors and does not check the corresponding documentation specifically looking at those dates. CNS-E stated the physician knows these residents are non-compliant with medications at times. Licensee's undated Safe Medication Assistance and Administration Policy indicated any occurrence of a medication dose not administered as prescribed, whether by error or refusal, should be documented on the MAR and reported to whom the MAR directs them to report to. DOCUMENTATION OF INITIALS ON DATES ADMINISTERED R1 On October 19, 2023, at 4:00 p.m., the surveyor observed R1's MAR for October 2023. The October MAR lacked documentation for the following scheduled medication doses: - Vitamin D3 25 microgram (mcg) capsule by mouth once daily in the morning- scheduled for AM October 1, 2, 14, 15, 16, and 17, 2023. - olanzapine 10 milligram (mg) tablet by mouth at bedtime: scheduled for HS (hour of sleep) October 6 and 16, 2023. - propranolol 20 mg tablet by mouth three times daily: AM October 14, 15, and 16, 2023. - propranolol 10 mg tablet by mouth three times daily: Afternoon October 1, 2, 3, 4, 5, 6, 7, 8, 9, 13, 14, 15, 16, 17, 18, and 19, 2023. - propranolol 10 mg tablet by mouth three times	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 117 daily: HS October 16, 2023. R2 On October 19, 2023, at 4:00 p.m., the surveyor observed R2's MAR for October 2023. The October MAR lacked documentation for the following scheduled medication doses: - famotidine 20 mg tablet twice daily: AM October 1, 2, and 6, 2023. - famotidine 20 mg tablet twice daily: PM October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19, 2023. - benztropine 1 mg tablet twice daily: AM October 1, 2, and 6, 2023. On October 19, 2023, at 4:00 p.m., CNS-E stated they expect the ULPs to document in the MAR immediately after administering medications. CNS-E stated that was the process they were trained. The licensee's undated Procedure for Administering Oral Medications policy indicated the final step in the procedure for administering medications was to chart the medication administered on the MAR. DOCUMENTATION OF TIME ADMINISTERED On October 16, 2023, at 11:00 a.m., the surveyor observed the MAR to lack specific time of medication administration. The hour column on the MAR that directed ULPs when to administer the medications did not contain a specific time. The hour directed was AM, PM, AFT (afternoon), and HS (hour of sleep or bedtime). The ULP put their initials on the date corresponding with the hour on the MAR but did not enter a specific time the medication was administered. On October 18, 2023, at 2:15 p.m., via telephone	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01760	Continued From page 118 interview, CNS-E stated the MARs came from the pharmacy printed with the times as AM, PM, AFT, and HS. CNS-E was not aware the pharmacy might be able to change these directions if requested. CNS-E agreed it would be important to know specific times medications were administered. NO SUPPLY OF MEDICATION R1's MAR for October 2023 contained the following medications: - dermaphor ointment to apply topically twice daily as needed; - ibuprofen 400 mg one tablet by mouth every six hours as needed for pain; and - melatonin 5 mg capsule at bedtime as needed for sleep. On October 19, 2023, at 3:30 p.m., the surveyor observed a lack of medication supply in the medication cabinet for the following medications: - dermaphor ointment; - ibuprofen 400 mg tablets; and - melatonin 5 mg capsules. On October 19, 2023, at 4:00 p.m., via telephone interview, CNS-E stated they did not realize the medications were all gone, and CNS-E would order new medications to replace them. CNS-E stated it was the nurse's responsibility to maintain the medication supply. The licensee's policy manual did not contain a policy for medication management that met the requirements of current licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01770	Continued From page 119	01770			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2). 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: During the entrance conference on October 17, 2023, at 10:00 a.m., the office manager (OM)-C stated the licensee provided medication management services which included medication setup by the registered nurse (RN) for all residents. R1 R1's diagnoses included unspecified psychosis, personality disorder, and insomnia.	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 120 R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's Medication Administration Record (MAR), dated October 2023, contained all medications listed and had areas for the unlicensed personnel (ULP) to initial by the on the corresponding date and time when they administered a medication. The MARs lacked documentation that a RN had set up the medications. R2 R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's MAR, dated October 2023, contained all medications listed and had areas for the ULP to initial by the on the corresponding date and time when they administered a medication. The MARs lacked documentation that an RN had set up the medications. On October 18, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-E stated by telephone interview, they set up the medications weekly on Saturdays and document in the paper progress notes. On October 19, 2023, at 9:00 a.m., the surveyor reviewed paper progress notes for R1 and R2 for documentation of medication set ups. - R1 had notes present from January 24, 2023, to	01770		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01770	Continued From page 121 August 29, 2023. Each entry indicated medications were set up for seven days with no additional information about the set up. There were entries for January 24, 31, February 7, 14, 21, March 3, 17, April 1, 7, May 19, 26, June 21, July 1, and August 29. The following weeks had no notes present from CNS-E: March 19, April 9, 16, 23, 30, May 7, 29, June 4, 11, July 2, 9, 16, 23, 30, August 6, 13, 20, September 3, 10, 17, 24, October 1, 8, and 15, 2023. The paper progress notes that were documented lacked the name of medication, quantity of dose, times to be administered, and route of administration. In addition to the previous missing information, the weeks with no documentation lacked the name of the person completing the medication set up. - R2 did not have any paper progress notes present written by CNS-E related to medication set up. R2's record lacked the name of medication, quantity of dose, times to be administered, route of administration, and the person completing the medication set up. On October 19, 2023, at 4:00 p.m., CNS-E stated by telephone interview, the paper progress notes about recent medication set ups for both R1 and R2 were missing from the charts at the facility because CNS-E had taken them home with them. CNS-E stated they had removed the documents from both R1 and R2's charts and had them on the table documenting when they spilled a large cup of iced tea all over the documents on the table. CNS-E stated they brought the wet documents home with them to rewrite them. The surveyor requested photos of the old documents or rewritten documents to review but did not receive anything. The licensee's undated Safe Medication Assistance and Administration policy indicated	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
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01770	Continued From page 122 when the program is responsible for setting up medications, at the time of set-up, staff must document the date of set-up, name of medication, quantity of dose, times to be administered, and the route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01800 SS=C	144G.71 Subd. 11 Prescribed and nonprescribed medication The assisted living facility must determine whether the facility shall require a prescription for all medications the provider manages. The facility must inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to determine and inform residents whether a prescription shall be required for all medications the facility is managing, including over the counter and dietary supplements, prior to agreeing to manage those medications. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
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01800	Continued From page 123 The findings include: R1 R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. R1's Medication Administration Record (MAR), dated October 2023, included the following over the counter medications and dietary supplement with a current prescription: - vitamin D3 one capsule by mouth once daily with a current prescription. The MAR also included the following over the counter and dietary supplements that had expired prescriptions: - ibuprofen 400 milligram (mg) tablets one tablet by mouth every six hours as needed for pain; and - melatonin 5 mg capsule by mouth at bedtime as needed for sleep. R2 R2's diagnoses included schizophrenia and depression. R2's Home Health Aide Care Plan- Customized Living, dated October 2, 2022, indicated R2 received medication reminders, assistance with transportation, shopping, scheduling appointments, and mental health management. R2's MAR, dated October 2023, included the following over the counter medications and dietary supplements with current prescriptions: - famotidine 20 mg one tablet by mouth twice daily;	01800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
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01800	Continued From page 124 - omeprazole 20 mg one capsule by mouth every day at bedtime, and - diphenhydramine 25 mg one capsule by mouth every day as needed for insomnia. In addition to the above over the counter medications, R1 and R2 were also using over the counter Tylenol as needed without a prescription. On October 19, 2023, at 3:45 p.m., ULP-B stated they had regularly administered Tylenol to R1 per the instructions on the bottle label and to R2 on at least one occasion. On October 19, 2023, at 4:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated they had not attempted to get any orders for Tylenol for R1 or R2. CNS-E stated if it is a medication the residents are taking, they should have a prescription for it. CNS-E was not aware of a facility determination for requirement of a prescription for over the counter and dietary supplements. CNS-E stated no notification had been made to the residents about prescriptions for over-the-counter medications and dietary supplements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01800			
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later	01810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
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01810	Continued From page 125 administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide written directions for administration of over-the-counter medications available for resident request and administration at the facility for two of two residents (R1, R2). 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: R1 R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. On October 19, 2023, at 3:30 p.m., the surveyor	01810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
01810	Continued From page 126 observed an unlabeled bottle of Tylenol 500 milligram (mg) caplets on a shelf in the medicine cabinet. On October 19, 2023, at 3:30 p.m., unlicensed personnel (ULP)-F stated they had given Tylenol to the residents when they asked for it. ULP-F did not recall any specific times giving Tylenol to R2 but stated they had given Tylenol to R1 for headache and body aches on numerous occasions. When asked why it was not documented anyplace, ULP-F stated since Tylenol was not on the medication administration record there was no place to document it. ULP-F did not recall if they had ever notified the nurse of the Tylenol use. On October 19, 2023, at 3:45 p.m., ULP-B stated they had administered Tylenol to R1 per the instructions on the bottle label. ULP-B stated R1 asks for Tylenol when he has been out of the house for a night or longer for generalized achiness. ULP-B stated they prepared Tylenol per R1's request approximately one time per week for the last six months to one year. ULP-B stated they had told clinical nurse supervisor (CNS)-E about R1's Tylenol use because it was not in the MAR. ULP-B stated they had on at least one occasion administered Tylenol to R2. R1's record lacked any prescriber order for Tylenol, nor contained written directions for administration of Tylenol. R2's record lacked any prescriber order for Tylenol, nor contained written directions for administration of Tylenol. On October 19, 2023, at 4:00 p.m., via telephone interview, CNS-E stated they had not attempted	01810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
01810	Continued From page 127 to get any orders for Tylenol for R1 or R2. CNS-E stated they should have an order if they are using the Tylenol. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted to the licensee for services under the comprehensive home care license on May 19, 2021, and began receiving assisted living	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
01830	Continued From page 128 services on August 1, 2021. R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping. On October 17, 2023, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's medication administration record for October 2023 contained the following medications that lacked current prescriber orders: - Vitamin D3 15 twenty-five micrograms (mcg) one capsule by mouth once daily with most recent order on May 19, 2021; - dermaphor ointment apply topically twice daily as needed with most recent order on June 4, 2021; - ibuprofen 400 milligrams (mg) one tablet by mouth every six hours as needed for pain with most recent order on June 4, 2021; and - melatonin 5 mg one capsule by mouth at bedtime as needed for sleep with most recent order on October 6, 2021. On October 19, 2023, at 4:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated the pharmacy maintains orders for the prescriptions at the facility, and CNS-E did not retain physician's orders or notes from medical appointments at the facility. CNS-E stated there should be pharmacy slips at the facility for orders but there have not been any changes requiring a new order for a long time. CNS-E stated they were not aware of the requirement for orders to	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
01830	Continued From page 129 be renewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect both residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: MEDICATION CABINET LEFT UNLOCKED On October 17, 2023, at 11:15 a.m., the surveyor observed unlicensed personnel (ULP)-B unlock	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 130 the medication cabinet, obtain what they needed from the cabinet, leave the key in the lock, and walk away. On October 17, 2023, at 12:38 p.m., the surveyor observed the medication cabinet still unlocked with key in the lock. ULP-B was in the living room looking at their phone with their back to the kitchen where the cabinet was located. On October 17, 2023, at 1:15 p.m., ULP-F arrived at the facility with documents from the office. The surveyor observed the medication cabinet to remain unlocked at 1:30 p.m., when ULP-F left the facility to return to the office. On October 17, 2023, at 3:00 p.m., the surveyor observed the lock on the medication cabinet to be intact and locked securely again. MEDICATION CABINET KEYS NOT SECURED On October 18, 2023, at 11:00 a.m., the surveyor observed ULP-F had been in the kitchen for approximately twenty minutes, but the keys medication cabinet keys were in the living room on the desk. No one was in the living room at the time. R1 came upstairs to the kitchen and requested his medications from ULP-F. ULP-F checked his pockets for the keys, realized he did not have them, walked into the living room, and picked up the keys from the desk. On October 18, 2023, at 8:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated facility staff who are responsible for medications should always keep the key with them. CNS-E stated the medication cabinet should be always locked when it is not in use. No further information provided.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 131	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to remove expired medication from availability for use for two of two residents (R1, R2). In addition, the licensee failed to ensure time-sensitive medications were labeled with the date opened and medications were kept in the original containers for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at 11:00 a.m., the surveyor observed the medication cabinet in the facility	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 132 kitchen/ dining area and observed the following: EXPIRED MEDICATIONS The following medications were on the medication cabinet shelves sorted into plastic bags that included current medications for R1. - R1 nicotine gum 2 milligrams (mg) expired July 18, 2022; - R1 benztropine 2 mg expired April 3, 2023; - R1 benztropine 1 mg expired May 2, 2023; - R1 ibuprofen 400 mg expired June 3, 2022; and - R1 divalproex sodium 500 mg expired August 29, 2023. The medication cabinet also contained a large plastic shopping bag that included: - fluphenazine decanoate injection solution 15 boxes with open, empty, and partially used medication bottles; and - five medication bottles that were not expired but were medications that had "no longer in use" written on the labels for R1 and R2 including: 1. R1- two bottles of divalproex sodium 500 mg capsules; 2. R1- two bottles of divalproex sodium 250 mg capsules; and 3. R2- one bottle of famotidine 40 mg tablets. On October 19, 2023, at 4:00 p.m., via telephone interview, clinical nurse supervisor (CNS)-E stated their process for maintaining the medication storage area was to look through all of the medications when they completed weekly medication set up. CNS-E stated they did not notice the expired ibuprofen because they do not set it up as it is only taken as needed by R1. CNS-E stated they were not sure what to do with the discarded injection solution bottles, discontinued, and expired medications, but had recently found a Walgreens that would take them. CNS-E stated they had not had time to get that	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 133 done. TIME SENSITIVE MEDICATION - R1 fluphenazine decanoate 25 mg/ml injection solution- bottle currently in use. The fluphenazine decanoate bottle sticker, prescription label on bottle, and paper box lacked documentation of the opened-on date. The prescription label from Geritom pharmacy attached to bottle in use at facility indicated discard vial 28 days after opening. On October 18, 2023, at 8:00 p.m., via telephone interview, CNS-E stated time sensitive medications should be labeled with date opened by the person who opened the medication. In addition, CNS-E stated they may have missed dating some fluphenazine deconate injection solution bottles because they are the only person that handles the medication bottle for injection in the facility. ORIGINAL CONTAINER On October 16, 2023, at 11:00 a.m., the surveyor observed a small zip sealed plastic bag in the medication cabinet. The bag contained nine round white pills and an empty envelope. The bag had ink pen writing on it that indicated "PRN (as needed) benztropine 0.5 mg check BED" on one side and the other side had "CK 9/4/23" written on the bag. On October 16, 2023, at 11:15 a.m., ULP-A stated they did not know anything about the medications in the plastic bag and just left them alone. On October 18, 2023, at 2:15 p.m., via telephone interview, CNS-E stated they did not know anything about medications in a plastic bag, but	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 134 they planned to look at them when they visited the following Saturday. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, and	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(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
01910	Continued From page 135 quantity for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 R3 discharged from the licensee on April 25, 2022. R3's record lacked an assessment, service plan, care plan, and medication management plan. R3's progress note dated December 24, 2021, indicated registered nurse (RN)-H documented facility would manage medications. RN-H's notes indicated collaboration with M Health Fairview for warfarin orders, Northwest Respiratory for oxygen, and Genoa Pharmacy for medication delivery. Ongoing documentation by RN-H and clinical nurse supervisor (CNS)-E indicated nurses had set up medications and unlicensed personnel (ULP) were administering medications throughout R3's time living at the facility. R3's medication administration record (MAR) dated February 1, 2022, to February 28, 2022 indicated R3 received the following medications: - levothyroxine 100 micrograms (mcg) two and one-half tablets once daily to total 250mcg; - warfarin per medical doctor order dose once daily;	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
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01910	Continued From page 136 - aripiprazole 10 milligrams (mg) one tablet once daily; - levetiracetam 500 mg one table twice daily; - latanoprost 50 mcg per 1 milliliter (ml) one drop in each eye once daily; - oxcarbazepine 300 mg one tablet twice daily; - potassium chloride extended release one tablet once daily; - tiotropium 2.5mg/ inhale two puffs into lungs once daily; - bumetanide 2 mg one tablet once daily; - buprenorphine naloxone hydrochloride (hcl) 4.1 mg once daily ; - digoxin125 mcg one tablet once daily; - fluticasone inhaler two puffs twice daily; - multivitamin with folic acid 0.4 mg one tablet once daily; - albuterol hydrofluoroalkane (HFA) inhaler two puffs every four hours as needed; - acetaminophen 350 mg two tablets every four hours as needed; - hydroxyzine pamoate 25 mg every six hours as needed; - Lidocaine five percent (%) ointment to back and legs as needed; - melatonin 5 mg at bedtime as needed; and - oxygen per nasal cannula as needed. R3's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, and quantity. On October 18, 2023, at 3:53 p.m., office manager (OM)-C stated R3 picked up some of his things but left some things behind. OM-C stated R3 left a recliner and oxygen tanks at the facility. OM-C stated they assumed R3 picked up R3's medications but there was no documentation of it.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(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
01910	Continued From page 137 On October 18, 2023, at 4:06 p.m., the surveyor observed fifteen medium sized compressed oxygen tanks standing in the facility garage. OM-C stated the oxygen was left behind and the facility was not sure what to do with it. OM-C planned to contact Northwest Respiratory to follow up on getting the oxygen tanks picked up. On October 20, 2023, at 12:00 p.m., via telephone interview, CNS-E stated they did not recall what happened to R3's medications upon discharge from the facility. CNS-E stated, "it was quite a while ago". CNS-E did confirm no medication list was prepared by nursing as that was not something CNS-E has ever done. CNS-E was not aware R3's oxygen tanks were still at the facility without a planned disposition from nursing. On October 17, 2023, at 10:30 a.m., OM-C confirmed the three-ring binder in the home, Elite Nursing Services HWS (housing with services) Policies and Procedures Handbook, contained all the facility's policies. If a policy was not in the binder or listed in the binder's table of contents, they did not have any additional policies elsewhere. The binder lacked policy or procedural information related to resident discharge or medication disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02400 SS=C	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family,	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430			
(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
02400	Continued From page 138 guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all residents at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included unspecified psychosis, personality disorder, and insomnia. R1's Service Recipient Care Plan signed May 19, 2021, indicated R1 received medication reminders, behavior programming, assistance with housekeeping, and shopping.	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2023
NAME OF PROVIDER OR SUPPLIER ELITE NURSING SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 THURBER ROAD BROOKLYN CENTER, MN 55430		
(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
02400	Continued From page 139 On October 16, 2023, at 3:00 p.m., the surveyor observed, during a shift-to-shift report unlicensed personnel (ULP)- A stated to ULP-B that R1 had spent the night at their girlfriend's house and had not been home to facility yet today. ULP-B stated R1 preferred to go there because when the girlfriend visits the facility staff have her leave at 10:00 p.m. ULP-B stated R1 will sometimes sneak her in the backdoor at night, when the staff find out they ask her to leave, and she goes. On October 17, 2023, at 9:10 a.m., R1 stated they spend time at girlfriend's house instead of facility because she is not allowed to spend the night at facility. R1 stated staff make her leave at 10:00 p.m. On October 28, 2023, at 12:50 p.m. the office manager (OM)-C stated the residents could have guests overnight but would need to notify staff a few days in advance. R1 has not planned for overnight visits from guests and the staff do limit his evening guest to leaving at 10:00 p.m. to maintain a structured schedule. R1's Rental Agreement, dated May 19, 2023, indicated overnight guests were welcome to stay with residents in their room but limited to a maximum of twelve nights per year. There was also a limit indicated on nighttime outings, citing the building doors being locked at 11:00 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400			

Type: Full
Date: 10/17/23
Time: 19:00:00
Report: 1043231071

Food and Beverage Establishment Inspection Report

Page 1

Location:

Elite Nursing Services Inc
3100 Thurber Road
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0038648
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632286534
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

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

FACILITY DOES NOT HAVE AN ILLNESS LOG. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 10/16/23

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

3-302.11A(1)

**** Priority 1 ****

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

RAW SHELL EGGS STORED ON SHELF ABOVE FRESH FRUITS IN KITCHEN COOLER. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Comply By: 10/16/23

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

FACILITY DOES NOT HAVE A CLEAN UP KIT OR PROCEDURES. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 10/16/23

Type: Full
Date: 10/17/23
Time: 19:00:00
Report: 1043231071
Elite Nursing Services Inc

Food and Beverage Establishment Inspection Report

Page 2

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

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

FACILITY DOES NOT HAVE A THIN PROBE FOOD THERMOMETER. DISCUSSED WITH STAFF.
COMPLY WITH ABOVE RULE.

Comply By: 10/16/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

DISH MACHINE IS PERIODICALLY USED. NO INDICATOR IS AVAILABLE TO VERIFY THE
UTENSIL SURFACE TEMPERATURE. PROVIDE DISPOSABLE TEMPERATURE STRIPS/LABELS OR
A MAXIMUM REGISTERING THERMOMETER TO ENSURE DISHES ARE REACHING AT LEAST
160F.

Comply By: 10/16/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

FACILITY USES CHLORINE AS SANITIZER. NO TEST KIT AVAILABLE. DISCUSSED WITH STAFF.
COMPLY WITH ABOVE RULE.

Comply By: 10/16/23

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CFPM EMPLOYED. FACT SHEET PROVIDED WITH REPORT.

Comply By: 05/01/24

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

NO LABELS ON BULK CONTAINERS OF FLOUR AND SUGAR. COMPLY WITH ABOVE RULE.
STAFF CORRECTED ON SITE.

Comply By: 10/16/23

Type: Full
Date: 10/17/23
Time: 19:00:00
Report: 1043231071
Elite Nursing Services Inc

Food and Beverage Establishment Inspection Report

Page 3

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

KITCHEN COOLER IS NOT EQUIPPED WITH A THERMOMETER THAT MEASURES FOR AMBIENT AIR. DISCUSSED WITH STAFF. COMPLY WITH ABOVE RULE.

Comply By: 10/16/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

KITCHEN HANDWASHING SINK AND BATHROOM HANDWASHING SINK THAT IS USED BY STAFF WERE MISSING A HANDWASHING SIGN. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Comply By: 10/16/23

Food and Equipment Temperatures

Process/Item: MILK

Temperature: 40 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Process/Item: HOT DOG

Temperature: 40 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Process/Item: BUTTER

Temperature: 40 Degrees Fahrenheit - Location: COOLER

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	4	4

Discussed illness policy, sanitizer use, ware washing, temperature control, cleaning, vomit/fecal procedures, test kits, highly susceptible populations, food storage, and food handling.

Inspection was completed with the person in charge at the time, Edith Dunbar. Peggy Anderson was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

Facility currently has two residents with a maximum of four.

This facility has a residential kitchen with residential equipment (dish machine, cooler, and stove). The kitchen finishes and surfaces are well maintained.

Foods are provided by the facility and are mainly cooked by the residents under staff supervision. Staff cooks when it is requested by the residents.

Type: Full
Date: 10/17/23
Time: 19:00:00
Report: 1043231071
Elite Nursing Services Inc

Food and Beverage Establishment Inspection Report

Page 4

Food must be prepared for same day service only with leftovers discarded.

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 1043231071 of 10/17/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Edith Dunbar
Person in Charge

Signed: _____

Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us