



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 21, 2024

Licensee

Chase Courageous Health Services LLC

7708 Regent Avenue North

Brooklyn Center, MN 55443

RE: Project Number(s) SL35083015

Dear Licensee:

On October 17, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 8, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 8, 2024 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 8, 2024, found not corrected at the time of the October 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4)

1290 - Background Studies Required - 144g.60 Subdivision 1 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on October 17, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on October 17, 2024, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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 cursive script that reads "Jessie Chenze". The ink is dark and the signature is fluid.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/17/2024
NAME OF PROVIDER OR SUPPLIER CHASE COURAGEOUS HEALTH SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 7708 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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: SL35083015-1 On October 9, 2024 through October 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 8, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant 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 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 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;	{0 250}			

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{0 250}	Continued From page 2 (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: This correction order was not reviewed during this follow up survey.	{0 250}			
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept	0 340			

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0 340	Continued From page 3 electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed October 17, 2024. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the revisit survey on October 9, 2024, through October 17, 2024, the surveyor reviewed the licensee's policies and procedures, reviewed employee records, and conducted interviews with program administrator (PA)-A. In addition, On October 17, 2024, the Minnesota Department of Health (MDH) engineering team conducted observations, interviews with PA-A and reviewed facility records. The licensee lacked evidence to	0 340			

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0 340	Continued From page 4 indicate the orders initially issued on August 8, 2024, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{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: This correction order was not reviewed during this follow up survey.	{0 480}			
{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 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	{0 510}			

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{0 510}	Continued From page 5	{0 510}			
	by: This correction order was not reviewed during this follow up survey.				
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	{0 680}			

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{0 680}	Continued From page 6 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: This correction order was not reviewed during this follow up survey.	{0 680}			
{0 780} SS=C	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	{0 780}			

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{0 780}	Continued From page 7 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 17, 2024, at 1:25 p.m. during an interview, survey staff asked the program manager (PA)-A if the smoke alarm system had been addressed and corrected. The PA-A stated they bought new wireless battery-type smoke alarms and had hired multiple contractors to	{0 780}			

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{0 780}	Continued From page 8 address the smoke alarm installation. Approximately from, 1:30 p.m. to 2:30 p.m., survey staff toured the home with the PA-A. During the home tour, survey staff observed the PA-A tested the new smoke alarms for the main- and lower-level floor bedrooms and hallways of the home, and the smoke alarms were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. During an interview, the PA-A stated that the new smoke alarms were tested and interconnected properly before the survey staff was on site. The PA-A verbally confirmed the above deficient findings at the time of discovery. October 17, 2024, at approximately 2:30 p.m., during an interview, survey staff explained to the PA-A that the deficient findings would be re-issued. The PA-A understood and acknowledged the findings. No further information was provided.	{0 780}			
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	{0 800}			

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{0 800}	Continued From page 9 by: Based on observation and interview, the licensee failed to maintain the physical environment of resident bedroom 1 in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the resident inside bedroom 1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 17, 2024, from approximately, 1:30 p.m. to 2:30 p.m., survey staff toured the home with the program manager (PA)-A. During the home tour, survey staff observed inside the main level bedroom 1 had a large and wide bed headboard obstruction that covered the egress window in its entirety preventing access to the window for immediate use during a fire or similar emergency. During an interview, the PA-A stated they had not had the opportunity to trash the headboard since it is heavy, but they planned on discarding the bedboard as soon as possible. The above deficient finding was visually and verbally verified by PA-A at the time of discovery. October 17, 2024, at approximately 2:30 p.m., during an interview, survey staff explained to the	{0 800}			

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{0 800}	Continued From page 10 PA-A that the deficient condition would be re-issued. The PA-A understood and acknowledged the finding. No further information was provided.	{0 800}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	{01060}			

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{01060}	Continued From page 11 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01060}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 12 licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of one employee registered nurse (RN)-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: RN-F had a hire date of February 22, 2022. RN-F's BGS clearance letter dated April 13, 2022, was cleared; however, was affiliated with the licensee's comprehensive HFID license 34166 and not the affiliated to the licensee's assisted living HFID 35083. On October 11, at 10:34 a.m., program administrator (PA)-A stated RN-F covered on call for weekends and holidays for the licensee and originally was hired under the licensee's comprehensive license. PA-A stated he only conducted one BGS for RN-F and had not conducted a BGS for RN-F under the assisted living licensee. The licensee's undated Conducting a Background Check Policy Procedure and Plan of Action, indicted the licensee would ensure each candidate hired would met Minnesota Department of Health (MDH) requirements and would be	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 13 affiliated with HFID 35083. No further information was provided.	{01290}			
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, 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	{01370}			

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{01370}	Continued From page 14 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: This correction order was not reviewed during this follow up survey.	{01370}			
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01380}			

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{01450}	Continued From page 15	{01450}			
{01450} SS=F	144G.62 Subd. 5 Documentation A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01450}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	{01470}			

Minnesota Department of Health

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{01470}	Continued From page 16 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01470}			
{01610} SS=D	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.	{01610}			

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{01610}	Continued From page 17 (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: This correction order was not reviewed during this follow up survey.	{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	{01620}			

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{01620}	Continued From page 18 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: This correction order was not reviewed during this follow up survey.	{01620}			
{01710} SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01710}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	{01760}			

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{01760}	Continued From page 19 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: This correction order was not reviewed during this follow up survey.	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	{01790}			

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{01790}	Continued From page 20 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01790}			

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{01830} SS=D	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: This correction order was not reviewed during this follow up survey.	{01830}			
{01890} SS=E	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: This correction order was not reviewed during this follow up survey.	{01890}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	{01940}			

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{01940}	Continued From page 22 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: This correction order was not reviewed during this follow up survey.	{01940}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	{02290}			

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{02290}	Continued From page 23 This correction order was not reviewed during this follow up survey.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 17, 2024

Licensee

Chase Courageous Health Services LLC

7708 Regent Avenue North

Brooklyn Center, MN 55443

RE: Project Number(s) SL35083015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER CHASE COURAGEOUS HEALTH SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 7708 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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: SL35083015-0 On August 5, 2024, through August 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom were receiving services under the provider's Assisted Living Facility license. Immediate orders for tag identification 0495 and 1290 were issued on August 5, 2024. An immediate order for tag identification 0820 was issued on August 6, 2024. The immediacy of orders 0495, 0820, and 1290 was removed effective August 7, 2024, based on surveyor observation and supervisor review.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1	0 250			
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 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;	0 250			

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

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0 250	Continued From page 3 The findings include: During the entrance conference on August 5, 2024, at 10:00 a.m., agent/house manager (A/HM)-E stated the licensee's employees in charge of the facility 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			

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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			

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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 six was electronically signed by A/HM-E on May 6, 2024. The licensee had an assisted living license issued on September 1, 2024, with an expiration date of August 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial evaluations of residents' needs and the providers' ability to provide those services;	0 250			

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0 250	Continued From page 6 - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - 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 August 5, 2024, at 10:00 a.m., A/HM-E confirmed the licensee provided assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, 26 licensing orders were issued, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	0 250			

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0 250	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 8	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
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 interview and record review, the licensee failed to ensure a registered nurse (RN) was available 24 hours a day, seven days a week. This had the potential to affect all residents and staff. This resulted in an immediate correction order on August 5, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Clinical nurse supervisor (CNS)-D was hired to provide nursing services for the licensee on February 15, 2023. On August 5, 2024, at 10:20 a.m. during the entrance conference, agent/housing manager (A/HM)-E stated the licensee only had one nurse. They had a backup nurse, but the last time they worked was in the year 2022. In addition, A/HM-E stated the backup nurse was never listed	0 495			

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0 495	Continued From page 9 on the on-call schedule. On August 5, 2024, at 10:53 a.m. CNS-D stated they would not be available for resident assessments if needed over the weekend or on holidays. On August 5, 2024, at 12:13 p.m. CNS-D stated they worked eight hour shifts, five times per two-week schedule at a hospital as a floor nurse in a mental health unit. CNS-D stated while they worked at the hospital, they would not be able to leave their shift, but they could return phone calls as able. The licensee's undated, Provision for On-Call Nurse Availability policy indicated a registered nurse shall be available for consultation and support whenever the employees are providing services to clients. The on-call person must always be available, in person, by pager or telephone. This policy is referenced to 144A home care statue and not 144G assisted living statue. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective August 7, 2024, based on surveyor observation and supervisor review.	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.	0 510			

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0 510	Continued From page 10 (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 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 infection control (IC) program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 August 5, 2024, at 11:21 a.m., during a tour of the facility, the surveyor observed no soap or towels available in the bathroom on the main level or in the bathroom on the lower level of the facility for handwashing. On August 6, 2024, at 8:08 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-B wash hands in sink	0 510			

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0 510	Continued From page 11 on lower-level bathroom using no soap and then proceeded to the office with wet hands and used a roll of toilet paper sitting on the desk to dry hands prior to assisting with medications for three residents. Also, the surveyor observed ULP-B don (put on) and doff (take off) gloves with each medication pass but failed to wash hands before and after donning and doffing gloves. On August 6, 2024, at 8:50 a.m., during continuous observation, the surveyor observed ULP-B going out to the garage to get a mop and bucket while still wearing gloves after assisting R3 with medications. ULP-B then proceeded to clean the bathroom floor on the lower level while still wearing the same gloves. After ULP-B cleaned the bathroom floor using the mop, ULP-B doffed the gloves and washed their hands without using soap and dried the hands in the office using a roll of toilet paper in the office. ULP-B then proceeded to don gloves and assist R2 with their medications. On August 6, 2024, at 9:01 a.m., during the continuous observation, the surveyor observed ULP-B going into a food pantry to retrieve coffee for a resident while wearing the same gloves used to assist R2 with medications. ULP-B was observed removing the gloves after going into the pantry but did not wash their hands. ULP-B then went back into the pantry to return the coffee after a resident was done making their coffee. On August 7, 2024, at 11:27 a.m., the surveyor observed no soap or towels available in the upstairs bathroom for handwashing. ULP-B was hired March 22, 2024. ULP-B's personnel record lacked training and/or	0 510			

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0 510	Continued From page 12 competency for basic infection control and hand washing. On August 5, 2024, at 12:21 p.m., ULP-B stated they were trained by the nurse on medications that included properly washing hands prior to the task. On August 6, 2024, at 10:55 a.m., clinical nurse supervisor (CNS)-D stated staff were supposed to properly wash hands prior to assisting with medications and should be wearing gloves if touching medications since some medications can be harmful to touch. CNS-D stated all staff had been trained and competency tested for handwashing. CNS-D stated the facility had a sign posted for hand washing procedure and stated the facility had re-occurring issues with staff not replacing soap and towels when empty. On August 8, 2024, at 11:51 a.m., agent/housing manager (A/HM)-E stated the licensee was not aware of the training requirement for basic infection control. A/HM-E stated this training was missed as an oversight when they assigned the required training to new staff. The licensee's undated Hand Hygiene/Hand Washing/Hand Cleansing policy indicated hand washing would be performed before and after direct patient care, and before and after each procedure. The policy also indicated all employees were responsible for implementing hand hygiene/hand washing/hand cleansing following the proper procedure for hand washing when using soap and water. The licensee's undated Standard Precautions policy indicated principles of Standard precautions would be following by all employees.	0 510			

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0 510	Continued From page 13 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB Facility Risk Assessment, TB baseline screening, and initial TB-related training for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a	0 660			

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0 660	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) 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: The licensee lacked a Facility TB Risk Assessment. ULP-A ULP-A was hired October 25, 2023. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping, and assisting with medications. ULP-A's personnel record lacked baseline TB screening that included the three components of assessing for current symptoms or active TB disease, assessing TB risk factors and TB history, and testing for the presence of TB infection. ULP-A's personnel record also lacked initial TB-related training. ULP-B ULP-B was hired March 22, 2024. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2 and R3) with medication administration. ULP-B's personnel record lacked baseline TB screening that included the three components of assessing for current symptoms or active TB disease, assessing TB risk factors and TB	0 660			

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0 660	Continued From page 15 history, and testing for the presence of TB infection. ULP-B's personnel record also lacked initial TB-related training. On August 5, 2024, at 10:40 a.m., agent/housing manager (A/HM)-E provided a blank Facility TB Risk Assessment and stated the form should have been completed. On August 5, 2024, at 10:41 a.m., clinical nurse supervisor (CNS)-D acknowledged the Facility TB Risk Assessment was not completed and stated they did not know how to complete a TB risk assessment. On August 6, 2024, at 11:01 a.m., CNS-D stated the licensee does perform TB screening at hire, however they shared responsibilities with [A/HM-E] and believed this was an oversight as they were not given the TB screening forms to complete when employees were hired. The licensee's undated Occupational Exposure to Tuberculosis/Prevention of Transmission of TB Plan policy indicated the licensee would comply with current CDC guidelines. The policy indicated the administrator/director of clinical services would perform annual and ongoing risk assessment surveillance, and all employees would receive education regarding TB before initial assignment and then annually. Also, the policy indicated new employees would produce recent (within 12 months) evidence of a negative PPD or chest x-ray prior to working with clients, however, this information is not updated with current CDC guidelines. The policy failed to identify the current CDC guidelines for initial TB screening. No further information provided.	0 660			

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0 660	Continued From page 16	0 660			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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 observation, interview, and record review, the licensee failed to develop and update annually, a written emergency disaster preparedness (EP) plan including all required	0 680			

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0 680	Continued From page 17 content. In addition, the licensee failed to post an emergency exit diagram on each floor. This affected all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Emergency Exit Diagram On August 5, 2024, at 11:21 a.m., during a tour of the facility, the surveyor did not observe an emergency exit diagram on the lower lever of the facility. On August 5, 2024, at 11:47 a.m., agent/housing manager (A/HM)-E stated they were not aware of the requirement to have an emergency exit diagram on each floor of the facility. A/HM-E stated the facility had an emergency exit diagram posted in the past, however this was removed about three to four months ago when the facility re-painted the walls and put new flooring in on the lower level of the facility. EP The licensee's undated EP plan was last reviewed on September 19, 2022, and lacked evidence of the following required content: - develop and maintain the EP; - EP program patient population; - process for EP collaboration; - development of EP policies and procedures; - subsistence needs for staff and patients;	0 680			

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0 680	Continued From page 18 - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; - development of Communication Plan; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training and testing; - emergency prep training program; and - emergency prep testing requirements. On August 6, 2024, at 2:08 p.m., A/HM-E acknowledged the licensee's EP was missing required information and stated the last review of the EP was September 19, 2022, as they were not aware the EP needed to be reviewed annually. The licensee's Emergency Preparedness policy dated November 1, 2021, indicated [licensee] would have an identified plan in place and reference CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z. The policy indicated the EP would be reviewed and updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780			

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0 780	Continued From page 19 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarms in the home and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 780			

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0 780	Continued From page 20 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, from 1:00 p.m. to 1:55 p.m., survey staff toured the home with agent/housing manager (A/HM)-E. During the tour, survey staff observed the following: -No smoke alarm was provided in the basement resident sleeping room 4. -The smoke alarm inside the basement resident sleeping room 5 failed to operate and sound when tested. -The smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The deficient finding was evident when the A/HM-E tested the smoke alarms in resident sleeping rooms 1, 2, and 3, and the hallways outside sleeping rooms on the main and basement level floors, each smoke alarm sounded local. The above deficient findings were verbally and/or visually verified by A/HM-E at the time of discovery. On August 6, 2024, at 2:55 p.m., survey staff explained the above deficient findings to A/HM-E during the exit interview. A/HM-E acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			

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0 790	Continued From page 21	0 790			
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, record review, and interview, the licensee failed to maintain the portable fire extinguishers as required. This had the potential to directly affect residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, from 1:00 p.m. to 1:55 p.m., survey staff toured the home with agent/housing manager (A/HM)-E. During the tour, survey staff	0 790			

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0 790	Continued From page 22 observed the portable fire extinguisher units mounted in the kitchen and the laundry area had not been serviced annually as required. The tag attached to each unit indicated the record of service date of December 2022. A/HM-E could not provide additional record of annual service for review. During an interview, the above deficient conditions were verbally verified by A/HM-E. On August 6, 2024, at 2:55 p.m., during an interview, survey staff explained the deficient findings to A/HM-E, and A/HM-E acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect	0 800			

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0 800	Continued From page 23 the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, from 1:00 p.m. to 1:55 p.m., survey staff toured the home with agent/housing manager (A/HM)-E. During the home tour, survey staff observed the following: -The furnace filter was filled with thick dust. At the time of discovery, A/HM-E attempted to replace the filter but found out the new filter was the incorrect size, 5-inch rather than 4-inch. as it did not fit. A/HM-E stated that he would buy the correct size and replace it. -Improper disposal of cigarette butts discarded on the grounds near the backyard deck areas next the door to the garage. Survey staff asked about the home's designated smoking area and a proper cigarette butt receptacle. A/HM-E verified the finding and stated that they have a proper cigarette butt receptacle for proper disposal but did not know where it went. A/HM-E finally found the cigarette butt receptor when A/HM-E looked under the deck. -The end run of the accessible ramp connecting to the home's main entry/exit door had a 1.5-inch drop where the ramp meets the driveway. In addition, exposed nails were observed at the end	0 800			

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0 800	Continued From page 24 of the ramp from a missing wood piece where the 1.5-inch drop exists. RESIDENT ROOM 1 -Pivacy window blinds were torn inside the resident sleeping room 1. -The large and wide bed headboard covered the entire egress window causing an obstruction for using the egress window doing a fire or similar emergency. -The door, door frame, and wood trim molding for room 1 were significantly damaged and comprimised. In addition, the door was missing a door strike plate and therefore, not allowing the door to latch when closed for resident privacy. RESIDENT ROOM 2 -The flooring inside resident sleeping room 2 was unmaintained and dirty. -A 6-inch by 12-inch penetration on the wall behind the door. A/HM-E stated that the resident is in the process of moving out and they will repair and clean the room. RESIDENT ROOM 5 -The door to resident sleeping room 5 was not operable. The door was missing the lower hinge and the door did not properly open and close. -A window screen was missing to prevent the entry of insects. MAIN LEVEL BATHROOM -The toilet seat and cover were loose and not secured. It shifted halfway off the bowl when moved. -The bathroom door was damaged with a 2-inch hole in it.	0 800			

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0 800	Continued From page 25 The above deficient findings were visually and/or verified by A/HM-E at the time of discovery. On August 6, 2024, at 2:55 p.m., during an interview, survey staff explained the deficient findings to A/HM-E, and A/HM-E understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

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0 810	Continued From page 26 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, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, from 1:00 p.m. to 1:55 p.m., survey staff toured the home with agent/housing manager (A/HM)-E. During the tour, survey staff observed the posted fire evacuation diagrams did not include room numbers for each resident bedroom. Evacuation plans must include the	0 810			

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0 810	Continued From page 27 location and resident sleeping room numbers. A/HM-E verified the finding at the time of discovery. On August 6, 2024, at 2:55 p.m., document and record review and interview with A/HM-E, on the home's fire safety and evacuation plan, Fire Safety, dated November 1, 2021, indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, A/HM-E verified that the fire safety and evacuation plan did not include 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 initial hire training. During an interview, A/HM-E showed survey staff their training material but also stated that they only had conducted drills as part of training. No other records were available or provided for review. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per shift per year with at least one evacuation drill every other month. Record review indicated that a total of one evacuation drill was conducted to date for the year 2024, but the record was incomplete and did not include time to indicate shift, and a total of three drills were conducted for calendar 2023, and one drill was conducted for 2022. During the interview, A/HM-E verified the finding and asked if the April 2024 drill would count for the 2024. Survey staff advised A/HM-E that they lacked the	0 810			

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0 810	Continued From page 28 minimum required drills to date and they would need to start the employee fire evacuation drills as soon as possible consisting of twice per shift per year, with at least one evacuation drill every other month. On August 6, 2024, at 2:55 p.m., during an interview, survey staff explained the above findings to A/HM-E, and A/HM-E acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810			
0 820 SS=H	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 constitute a distinct hazard to life. The licensee	0 820			

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0 820	Continued From page 29 failed to provide the minimum state standard-sized egress window for occupied resident sleeping room 2. This has the potential to directly affect the health, safety, and well-being of the resident in sleeping room 2 and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 6, 2024, from 1:00 p.m. to 1:55 p.m., survey staff toured the home with agent/housing manager (A/HM)-E. During the tour of the occupied main-level resident sleeping room 2, survey staff measured the clear openings of the two sets of sliding windows, with the largest window dimensions at, height at 31.5 inches, and width at 17 inches, totaling a clear opening area of 535.5 square inches, which did not meet the minimum state-standard for existing egress windows. Survey staff explained to A/HM-E that at least one of the two windows in room 2 must have the required state standard-sized egress window in each sleeping room with a minimum width and height of no less than 20 inches of clear opening, and a minimum total open area of 648 square inches (4.5 square feet) required for safe egress for existing windows. A/HM-E verified the deficient finding and stated that he planned to replace the window when the resident moved out end of week this Friday.	0 820			

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0 820	Continued From page 30 The above deficient finding was verbally and visually verified with A/HM-E at the time of discovery accompanying the tour. On August 6, 2024, at 2:15 p.m., during an interview, survey staff explained to A/HM-E that a distinct hazard order was issued for the above deficient finding and a plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. A/HM-E understood and acknowledged the deficient finding and did not have further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective August 7, 2024, based on surveyor observation and supervisor review.	0 820			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060			

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01060	Continued From page 31 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1).	01060			

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01060	Continued From page 32 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: R1 was admitted to licensee on July 17, 2019, with diagnoses of bipolar, attention-deficit hyperactive disorder, stimulant use disorder and methamphetamine use disorder. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior, and cognitive behavior. R1's progress notes dated March 27, 2023, at 4:35 p.m., indicated R1 was sent to hospital by ambulance due to increase swelling and redness on R1's right foot. R1's progress notes dated April 3, 2023, at 2:00 p.m., indicated R1 returned to the facility by ambulance from hospital on April 1, 2023. R1 did not return from the emergency relocation within four days.	01060			

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01060	Continued From page 33 R1's record lacked documentation of R1, R1's legal representative, R1's designated representative, and the OOLTC received a written notice with all the required content for an emergency relocation. On August 8, 2024, at 12:36 p.m., clinical nurse supervisor (CNS)-D indicated they were not aware of the requirement to provide a written notice for emergency relocations and did not know they needed to contact OOLTC when the resident did not return from the emergency relocation within four days. On August 8, 2024, at 12:37 p.m., agent/housing manager (A/HM)-E stated the licensee would give a verbal notice if they had to relocate a resident and was not aware of the requirement of emergency relocation or the required content for a written notice. A/HM-E stated residents would have two weeks for the resident to return to the home from hospital, otherwise the licensee would not accept the resident back at the facility. A/HM stated the licensee did not have a policy for emergency relocation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290			

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01290	Continued From page 34 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed and cleared prior to staff providing services for one of two unlicensed personnel ((ULP)-A). This had the potential to affect all residents. This resulted in an immediate correction order on August 5, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on October 25, 2023, to provide direct care services and worked independently within the facility.	01290			

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01290	Continued From page 35 ULP-A's Background Study Notice dated October 16, 2023, was associated to a different assisted living facility (not owned by the licensee) with health facility identification number (HFID) 35842 and was not affiliated to licensee's assisted living facility with HFID 35083. On August 5, 2024, at 12:44 p.m., agent/housing manager (A/HM)-E stated ULP-A had provided a background study completed for a different licensee around the same time, so they did not conduct a background check for this license. On August 5, 2024, at 1:36 p.m., A/HM-E stated ULP-A provided direct cares to all residents at the licensee's facility. On August 5, 2024, at 3:13 p.m. A/HM-E further stated ULP-A has provided direct cares to residents without direct supervision. The licensee's undated, Employment Process policy indicated criminal background checks would be completed on all employees providing direct care services according to state statue. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective August 7, 2024, based on surveyor observation and supervisor review.	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370			

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01370	Continued From page 36 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01370			

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01370	Continued From page 37 review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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-A ULP-A was hired October 25, 2023, as a program administrator. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping and assisting with medications. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - hair care and bathing; - care of teeth, gums, and oral prosthetic devices;	01370			

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01370	Continued From page 38 - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; and - procedures to utilize in handling various emergency situations. ULP-B ULP-B was hired March 22, 2024, as a certified nursing assistant/home health aide to provide direct cares to residents. On August 6, 2024, at 9:46 a.m., the surveyor verified ULP-B was not listed on the Minnesota Nurse Aide Registry as a current Home Health Aide or Certified Nursing Assistant. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2, and R3) with medication administration. ULP-B's personnel record lacked evidence of completed training and/or competency testing for the following: - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - hair care and bathing; - care of teeth, gums, and oral prosthetic	01370			

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01370	Continued From page 39 devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - understanding appropriate boundaries between staff and residents and the resident's family. On August 6, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-D stated they were not aware of the training and/or competency evaluations required by statute; and they did not know the competency evaluations had to be documented. The licensee's undated Training and Competency Evaluation policy indicated a registered nurse would perform the training and competency evaluation to meet state guidelines for all unlicensed personnel; and the documentation of the training and/or competency would be maintained in the personnel file for each employee. The policy referred to home care services and not assisted living services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 40	01380			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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:	01380			

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01380	Continued From page 41 ULP-A ULP-A was hired October 25, 2023, as a program administrator. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping, and assisting with medications. ULP-A's personnel record lacked evidence of completed training and/or competency testing for the following: - observation, reporting, and documenting of residents status; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other professionally delegated tasks. ULP-B ULP-B was hired March 22, 2024, as a certified nursing assistant/home health aide to provide direct cares to residents. On August 6, 2024, at 9:46 a.m., the surveyor verified ULP-B was not listed on the Minnesota Nurse Aide Registry as a current Home Health Aide or Certified Nursing Assistant. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2 and R3) with medication administration. ULP-B's personnel record lacked evidence of	01380			

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01380	Continued From page 42 completed training and/or competency testing for the following: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other professionally delegated tasks. On August 6, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-D stated they were not aware of the training and/or competency evaluations required by statute; and they did not know the competency evaluations had to be documented. The licensee's undated Training and Competency Evaluation policy indicated a registered nurse would perform the training and competency evaluation to meet state guidelines for all unlicensed personnel; and the documentation of the training and/or competency would be maintained in the personnel file for each employee. The policy referred to home care services and not assisted living services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01450 SS=F	144G.62 Subd. 5 Documentation A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01450			

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01450	Continued From page 43 review, the licensee failed to ensure documentation of direct supervision of staff performing delegated tasks was maintained for two of two unlicensed personnel ((ULP-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-A ULP-A was hired October 25, 2023. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping, and assisted with medications. ULP-A's personnel record lacked documentation of direct supervision of delegated tasks by the registered nurse. ULP-B ULP-B was hired March 22, 2024. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2, and R3) with medication administration. ULP-B's personnel record lacked documentation of direct supervision of delegated tasks by the registered nurse.	01450			

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01450	Continued From page 44 On August 6, 2024, at 11:08 a.m., clinical nurse supervisor (CNS)-D stated they would observe unlicensed personnel perform nursing delegated services when present in the facility; and if they had seen any concerns, they would talk to the unlicensed personnel regarding those concerns at that time. CNS-D stated they did not see any supervision forms to document for the personnel record. The licensee's Supervision policy dated January 2020, indicated home health aides who provided nursing delegated services to assisted living residents would be supervised by a registered nurse within fourteen days of initiation of assisted living services and at least sixty-two days after. The policy failed to identify documentation of the direct supervision would be maintained in the personnel record. The policy referred to 144A statue and not 144G statue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01450			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470			

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01470	Continued From page 45 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470			

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01470	Continued From page 46 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-A ULP-A was hired October 25, 2023, as a program administrator. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping, and assisting with medications. ULP-A's personnel record lacked evidence of orientation training that included an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and handling of residents' complaints, reporting of complaints, and where to report complaints,	01470			

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01470	Continued From page 47 including information on the Office of Health Facility Complaints. ULP-B ULP-B was hired March 22, 2024, as a certified nursing assistant/home health aide to provide direct cares to residents. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2 and R3) with medication administration. ULP-B's personnel record lacked evidence of orientation training that included an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On August 6, 2024, at 11:35 a.m., agent/housing manager (A/HM)-E stated they had gone over agency policies and procedure during a meeting on November 17, 2022, but this training was missed for both ULP-A and ULP-B as an oversight at orientation. On August 8, 2024, at 11:46 a.m., licensed assisted living director (LALD)-C stated they will assign all the orientation training in Educare (a common online program used for training staff) and stated this was an oversight on not assigning all the required orientation. The licensee's undated Agency Employee Orientation policy indicated all employees would complete an orientation before providing services and it would include review of the facility's policies	01470			

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01470	Continued From page 48 and procedures related to the provision of home care services; and handling of residents' complaints, reporting of complaints to the Office of Health Facility Complaints. The policy referred to home care 144A statute and not assisted living 144G statute. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01610 SS=D	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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial	01610			

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01610	Continued From page 49 assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of one resident (R3) receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on August 2, 2024, with diagnoses that included anxiety and schizophrenia. On August 6, 2024, at 8:38 a.m., the surveyor observed ULP-B assist R3 with medication administration. On August 7, 2024, at 9:29 a.m., the surveyor requested R3's contract, R3's service plan, R3's initial assessment, and R3's individualized medication management plan. Agent/housing manager (A/HM)-E stated clinical nurse supervisor (CNS)-D had not completed the admission paperwork or assessment yet. On August 7, 2024, at 11:20 a.m., CNS-D stated R3's initial assessment was completed on August 6, 2024, but they had not completed the paperwork portion of the assessment yet. CNS-D stated they did not complete any other assessment prior to R3 moving in. CNS-D stated they were not aware of the statue requiring an	01610			

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01610	Continued From page 50 assessment to be completed prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in. The licensee's undated Comprehensive Client Assessment policy indicated an initial assessment would be completed within five days after the initiation of services. The policy referred to 144A statue and not 144G statue. No further 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	01620			

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01620	Continued From page 51 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 a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool 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 licensee on July 17, 2019. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive	01620			

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01620	Continued From page 52 behavior. R1's Notes dated May 22, 2024, through August 6, 2024, indicated R1 had assessments on June 7, 2024, July 15, 2024, and August 6, 2024. R1's monthly assessments failed to identify changes or updates to the last full comprehensive assessment and failed to address the required content per Minnesota Administrative Rule 4659.0150 at each subsequent assessment following the comprehensive assessment originally completed upon initiation of services. R2 R2 was admitted to licensee on September 26, 2022. R2's Service Plan dated September 26, 2022, indicated R2 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. R2's Notes dated May 22, 2024, through August 6, 2024, indicated R2 had assessments on January 3, 2024, February 5, 2024, March 4, 2024, April 4, 2024, May 3, 2024, June 3, 2024, and July 1, 2024. R2's monthly assessments failed to identify changes or updates to the last full comprehensive assessment and failed to address the required content per Minnesota Administrative Rule 4659.0150 at each subsequent assessment following the	01620			

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01620	Continued From page 53 comprehensive assessment originally completed upon initiation of services. On August 7, 2024, at 1:55 p.m., clinical nurse supervisor (CNS)-D stated the licensee was not aware of the required content per Minnesota Rule for all assessments and they would review the statue and the rule for the required content of the uniform assessment. On August 8, 2024, at 11:33 a.m., CNS-D stated when they performed monthly assessments, they would review the resident chart for medication concerns and issues with activities of daily living (ADLs) by reviewing the task sheets. CNS-D stated they do not refer to the last comprehensive assessment unless they are needing to know more about a resident. CNS-D stated they were not aware the assessments needed to be at least every 90 days but instead does the assessments every month. The licensee's undated Comprehensive Client Assessment policy indicated a comprehensive assessment would be completed by a registered nurse within five days after the initiation of services; and ongoing monitoring and reassessment would be conducted as needed based on changes in the needs of the client but could not exceed 90 days from the last date of assessment. The policy did not indicate if the ongoing monitoring and reassessments would include all the required content per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. The policy referred to 144A statue and not 144G statue. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or	01620			

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01620	Continued From page 54 reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments 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	01710			

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01710	Continued From page 55 or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to licensee on July 17, 2019, with diagnoses of Bipolar, attention-deficit hyperactive disorder, stimulant use disorder and methamphetamine use disorder. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. On August 6, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. R1's Individualized Medication Management Plan (IMMP) dated July 5, 2022, indicated R1 received set up of medications by the nurse. The IMMP did not indicate R1 received other medication management services such as medication reminders by staff or medication administration by facility staff. R1's Medication Assessment for Safety in Self Administration dated July 5, 2022, indicated R1 was deemed unable to safely self-administer medications.	01710			

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01710	Continued From page 56 R1's Medication Assessment/Delegation Form dated July 5, 2022, indicated R1 required assist with medications but did not indicate the frequency. The frequency lacked documentation as these areas were left blank on the assessment. R2 R2 was admitted to licensee on September 26, 2022, with diagnosis of schizophrenia. R2's Service Plan dated September 26, 2022, indicated R2 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. On August 6, 2024, at 8:55 a.m., the surveyor observed ULP-B assist R2 with medication administration. R2's IMMP dated September 26, 2022, indicated R2's medication management services included medication reminders, medication administration by facility staff and set up of medication by facility nurse. R2's Medication Assessment for Safety in Self Administration dated September 26, 2022, indicated R2 was deemed unable to safely self-administer medications.	01710			

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01710	Continued From page 57 R2's Medication Assessment/Delegation Form dated September 26, 2022, indicated R2 required aide assist with medications twice daily. R1 and R2's records lacked an annual reassessment of the medication management services. On August 7, 2024, at 1021 a.m., agent/housing manager (A/HM)-E stated R1's most recent medication assessment was completed on July 5, 2022; and R2's most recent medication assessment was completed on September 26, 2022. On August 7, 2024, at 10:48 a.m., clinical nurse supervisor (CNS)-D stated they were not aware they needed to complete annual medication re-assessments with required documentation and stated they complete a medication reconciliation with each medication set up that included checking for new orders and medication compliance. The licensee's undated Medication Management Services policy indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines. The policy did not indicate the reassessment of the resident's medication management services needed to be completed at least annually. The policy referenced Minnesota Statutes 144A related to home care, not 144G related to assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710			

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760			

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01760	Continued From page 59 R1 was admitted to licensee on July 17, 2019. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. On August 6, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. During the observation, the surveyor did not observe ULP-B administer levothyroxine or meloxicam. R1's medication administration record (MAR) for August 2024, indicated ULP-B administered R1's levothyroxine and meloxicam as prescribed. R1's MAR dated August 2024, (copy of MAR, used only by the nurse to document each medication set up) had a line written through levothyroxine and meloxicam for the entire month indicating these medications were not set up August 1, 2024, through August 7, 2024. R1's note dated July 24, 2024, indicated medications were set up until July 31, 2024. R1's meloxicam and levothyroxine had no refills and were waiting for provider approval. R1's note dated July 31, 2024, indicated medications were set up until August 7, 2024; R1	01760			

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01760	Continued From page 60 was compliant with medications; and no new orders. The note did not indicate if levothyroxine and/or meloxicam were added or omitted from the medication set up. R1's notes dated July 24, 2024, through August 6, 2024, lacked documentation of follow up on levothyroxine and meloxicam and did not indicate if R1's provider was notified of R1 not receiving the medications as prescribed. On August 7, 2024, at 11:07 a.m., clinical nurse supervisor (CNS)-D stated [R1] did not have levothyroxine or meloxicam in August as pharmacy needed to get approval from R1's provider before refilling the medications. CNS-D stated they called R1's provider and was told R1 was no longer a patient of that provider. CNS-D stated R1 was in the process of establishing care with a new provider and was given a temporary provider to help with orders but have not received new orders or the medication yet. On August 8, 2024, at 12:10 p.m., CNS-D stated when medications were not given as prescribed, the staff should be documenting the reason why it was not administered and stated they will need to further educate staff on documentation of medications. The licensee's undated Content of Client's Medication Records policy indicated if medication were not administered as prescribed the reason why the medication was not given would be documented in the record along with any follow up procedures that were provided. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information was provided.	01760			

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01760	Continued From page 61	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790			

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01790	Continued From page 62 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01790			

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01790	Continued From page 63 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-A ULP-A was hired October 25, 2023. On August 5, 2024, at 1:36 p.m., agent/housing manager (A/HM)-E stated ULP-A provided direct cares to residents that included personal cares, housekeeping, and assisted with medications. ULP-A's personnel record lacked documentation ULP-A was trained and found competent by the licensee to provide medications to residents who had unplanned times away. ULP-B ULP-B was hired March 22, 2024. On August 6, 2024, at 8:06 a.m., the surveyor observed ULP-B assisted three residents (R1, R2 and R3) with medication administration. ULP-B's personnel record lacked documentation ULP-B was trained and found competent by the licensee to provide medications to residents who had unplanned times away. On August 8, 2024, at 12:03 p.m., clinical nurse supervisor (CNS)-D stated unlicensed personnel had performed medication set up for unplanned times away for residents as they would put the doses in separate dosage baggies. CNS-D stated they were not aware of the statue and	01790			

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01790	Continued From page 64 stated they did not provide the training to unlicensed personnel prior to performing the task. The licensee's Medication Management for Client Unplanned Time Away policy dated January 2020 indicated unlicensed personnel would be trained and deemed competent by a registered nurse prior to performing the task and documentation of the training would be maintained in the personnel record. The policy referred to 144A statue and not 144G statue. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790			
01830 SS=D	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 observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01830			

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01830	Continued From page 65 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on July 17, 2019. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. On August 6, 2024, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. R1's Medication & Treatment Orders dated August 14, 2020, was identified by agent/housing manger (A/HM)-E as R1's most recent orders. On August 7, 2024, at 10:25 a.m., clinical nurse supervisor (CNS)-D stated they have not renewed the residents' orders annually as they were not aware of the statue. CNS-D stated the orders would go through the pharmacy and if there were any concerns or questions they would follow up with the provider as needed. The licensee's undated Content of Client Medication Records policy indicated the resident's record must contain written or electronic prescriptions that are complete and	01830			

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01830	Continued From page 66 current for any medications managed for the resident. The policy lacked information on annual renewal of prescriptions at least every twelve months. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for three of three residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01890			

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01890	Continued From page 67 The findings include: On August 7, 2024, at 1:01 p.m., the surveyor observed the licensee's medications storage cabinet and observed the following expired medications: R1's acetaminophen expired April 13, 2024; R1's olopatadine hydrochloride ophthalmic expired June 2024; R2's metformin expired March 12, 2024; R4's acetaminophen/codeine expired July 19, 2024; R4's ibuprofen expired July 12, 2024; and R4's amoxicillin-clavulanate expired July 19, 2024. On August 7, 2024, at 1:38 p.m., clinical nurse supervisor (CNS)-D acknowledged medications were expired and indicated they look at the medication expiration dates prior to setting up medications and stated if they were expired and still in the resident's medication box then they did not get to destroy them yet. The licensee's undated Medication Storage policy lacked information related to expired medications. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940			

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01940	Continued From page 68 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER CHASE COURAGEOUS HEALTH SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 7708 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01940	Continued From page 69 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: R1 was admitted to licensee on July 17, 2019, with diagnoses of bipolar, attention-deficit hyperactive disorder, stimulant use disorder and methamphetamine use disorder. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. R1's Discharge Instructions dated April 1, 2023, following a hospitalization, indicated care instructions for wound on right thumb and wound on right foot. R1's Individualized Treatment or Therapy Management Plan dated July 5, 2022, indicated R1 received a treatment for vital signs and did not include a treatment type for wound care. On August 8, 2024, at 12:52 p.m., clinical nurse supervisor (CNS)-D indicated R1's treatment plan and service plan were not updated following a hospital discharge on April 1, 2023, after	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
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01940	Continued From page 70 receiving hospital discharge instructions with new treatments for wound care. CNS-D was not aware they needed to create a treatment plan and update the service plan. The licensee's undated Individualized Treatment or Therapy Plan policy indicated licensee would develop an individualized plan for each resident who had received treatment or therapy services; and the licensee would request orders based on the individuals need. Also, the policy indicated the treatment would be incorporated into the service plan. The policy referenced Minnesota Statutes 144A related to home care, not assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER CHASE COURAGEOUS HEALTH SERVICES LL			STREET ADDRESS, CITY, STATE, ZIP CODE 7708 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443		
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02290	Continued From page 71 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: R1 was admitted to licensee on July 17, 2019. R1's Service Plan dated July 16, 2022, indicated R1 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; treatments and exercises; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. R1's Resident Contract for Assisted Living, dated November 7, 2022, indicated by R1 signing the agreement, they agreed to abide by and comply with all the assisted living rules. R2 was admitted to licensee on September 26, 2022. R2's Service Plan dated September 26, 2022, indicated R2 received the following services: dressing; self-feeding; oral hygiene; hair care; grooming; toileting; bathing; standby assistance; medication reminders; preparation of modified diets; medication administration; hands-on assistance with transfers and mobility; eating assistance; laundry; housekeeping; and management of orientation, agitation, verbal	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
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02290	Continued From page 72 aggression, anxiety, physical aggression, wandering, self-injury behavior and cognitive behavior. R2's Resident Contract for Assisted Living, dated September 26, 2022, indicated by R2 signing the agreement, they agreed to abide by and comply with all the assisted living rules. On August 5, 2024, at 11:12 a.m., during a tour of the facility, the surveyor observed a posting on the wall in the dining room common area labeled, [licensee] House Rules and Regulations. The undated [licensee] House Rules and Regulations read the following: 1. Absolutely NO alcohol will be permitted while you are a resident of [licensee]. This always applies including when you are away from [licensee]; 2. The Manager and Staff reserve the right to perform random room search deemed necessary to insure the serenity and security of the home. This includes personal items and vehicles if appropriate; 3. House curfew is 10:00 p.m. every night. The doors will be locked at that time unless approved by the house manager. Any resident returning after 10:00 p.m. must find other sleeping arrangements for the night. Three times of late return to home in the same month will result in discharge; and 4. All visitors are subject to the approval by staff. No visitor is permitted on the property while under the influence of alcohol or drugs. No visitors are allowed in the house before 9:00 a.m. or after 9:00 p.m. On August 8, 2024, at 11:01 a.m., agent/house manager (A/HM)-E stated the licensee tried to	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2024
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02290	Continued From page 73 enforce the house rules. A/HM-E stated they had a resident in the past drink alcohol in the facility and they had to take the alcohol away from that resident, however the resident decided to move out since alcohol was not allowed in the facility. A/HM-E stated the residents were allowed to have visitors until 10:00 p.m. and indicated the facility had not had any previous situations that violated the visiting hours as A/HM-E had explained the rules to all the residents. A/HM-E stated if a resident needed to be out of the home past 10:00 p.m., then the resident would need to notify staff prior so they would be allowed back in the facility. On August 8, 2024, at 11:14 a.m., A/HM-E indicated the licensee was not aware they could not have house rules and they would remove the posting of the house rules in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

Type: Full
Date: 08/06/24
Time: 10:40:00
Report: 1013241061

Food and Beverage Establishment Inspection Report

Page 1

Location:

Chase Courageous Hlth Services
7708 Regent Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0038498
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127079072
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.

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.

FACILITY'S DISH MACHINE SANITIZES WARE WITH HOT WATER. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE. DISCUSSED SANITIZER TESTING PROCEDURES WITH STAFF.

Comply By: 08/20/24

6-300 Physical Facility Numbers and Capacities

6-301.11 **** Priority 2 ****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP WAS AVAILABLE AT THE HAND WASHING SINK. STAFF STOCKED SOAP.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS OR HAND DRYING DEVICE WAS AVAILABLE AT THE HAND WASHING SINK. STAFF STOCKED PAPER TOWELS.

Corrected on Site

Type: Full
Date: 08/06/24
Time: 10:40:00
Report: 1013241061
Chase Courageous Hlth Services

Food and Beverage Establishment Inspection Report

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

GRIME BUILD UP ON KITCHEN CABINETS AND MICROWAVE EXTERIOR. GRIME AND DEBRIS BUILD UP INSIDE CABINET BELOW THE SINK. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.

8/7/24

OPERATOR EMAILED PICTURES OF CLEANED AREAS. CLEAN CABINET BELOW SINK.

Comply By: 08/06/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Cheese
Temperature: 38 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator R. Quinehan.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

Type: Full
Date: 08/06/24
Time: 10:40:00
Report: 1013241061
Chase Courageous Hlth Services

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013241061 of 08/06/24.

Certified Food Protection Manager Oladimeji Olantunji

Certification Number: 111135 Expires: 05/17/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Chase Mulbah
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us