



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 31, 2025

Licensee

Angel's Health & Home Care Services Inc.
4213 63rd Avenue North
Brooklyn Center, MN 55429

RE: License Number 418161
Health Facility Identification Number (HFID) 35639
Project Number(s) SL35639015

Dear Licensee:

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

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 25, 2024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 6, 2025, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1760 - Documentation Of Administration Of Medication - 144g.71 Subd. 8

The details of the violations noted at the time of this follow-up survey completed on January 6, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

Also, at the time of this follow-up survey completed on January 6, 2025, we identified the following violation(s):

0660 - Tuberculosis Prevention And Control - 144g.42 Subd. 9

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.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

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>

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,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/06/2025
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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: SL35639015-4 On January 6, 2025, 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 January 25, 2024, and follow-up surveys completed on April 17, 2024, July 31, 2024, and September 17, 2024. At the time of the survey, there were three residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or 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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1	{0 480}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
0 660 SS=E	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.	0 660			

Minnesota Department of Health

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0 660	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening for one of three employees (unlicensed personnel (ULP-R) and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (ULP-Q, ULP-R). 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). The findings include: The licensee's Survey Corrective Action Plan (CAP) indicated on November 1, 2024, the licensee obtained a QuantiFERON gold TB blood test for ULP-Q. In addition, newly hired employees were to complete a two-step TST, blood test, or chest Xray prior to employment, and the administrator was to audit new employee files to ensure the licensee had received a TB screening prior to employment start date. ULP-Q ULP-Q was hired on December 28, 2022, to	0 660			

Minnesota Department of Health

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0 660	Continued From page 4 provide direct care services to residents. ULP-Q's record included a health history and symptom screening dated December 28, 2022, and positive QuantiFERON gold TB blood test dated September 23, 2024. ULP-Q's record lacked a chest Xray after receiving a positive TB blood test to demonstrate ULP-Q was negative for TB. ULP-R ULP-R was hired on October 11, 2024, to provide direct care services to residents. ULP-R's record included a one-step TST completed on December 19, 2024. ULP-R's record lacked a health history and symptom screening and the second step TST. On January 6, 2025, at 12:36 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated they were in charge of reviewing the employees TB results. CNS/RN-A stated employees needed to have a two-step TST or a TB blood test within 90 days of employment or a chest Xray prior to working. CNS/RN-A stated they believe the test results were misplaced due to newly hired employees in the business office. ULP-Q joined the conversation and stated they did not complete a chest Xray after the positive QuantiFERON gold TB blood test. CNS/RN-A stated they did not read that ULP-Q's TB test was positive and they would send ULP-Q for a chest Xray. After the survey concluded, the surveyor received an email from the licensee on January 13, 2025, that included ULP-Q's chest Xray completed January 10, 2025, and ULP-R's QuantiFERON gold TB blood test completed January 9, 2025, indicating both TB screens were completed after	0 660			

Minnesota Department of Health

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0 660	Continued From page 5 the survey. The CDC's document titled Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, indicated all health care personnel should be screened for TB upon hire. TB screening includes a baseline individual TB risk assessment, TB symptom evaluation, TB test which included a TB blood Test or TB skin test. The licensee's undated Tuberculosis Screening policy read, "Each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
{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}			

Minnesota Department of Health

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{0 800}	Continued From page 6 by:	{0 800}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately document the dosage of medication that was administered for one of three residents (R6). 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).	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 8 The findings include: The licensee's Survey Corrective Action Plan (CAP) section titled Documentation of Administration of Medication dated October 28, 2024, indicated the licensee rephrased administration instructions for the unlicensed personnel (ULP) on the medication administration record (MAR) related to Senexon S. Staff would assess R6's bowel pattern prior to Senexon S administration and document the number of Senexon S tablets administered and R6's response to the bowel medication. In addition, the registered nurse (RN) would review the MAR weekly and ensure the protocol for administration of medications was being followed. R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's Discharge Instructions dated June 17, 2024, included Senexon-S 8.6 milligrams (mg)/ 50 mg take one to four tablets by mouth twice a day for post operation pain and constipation. R6 Med Amin Summary - Month dated September 2024 indicated "Senexon-S tab 8.6-50 mg (Daily) 1- 4 tablets by mouth twice daily for complaints of no bowel movement. (ASK ABOUT THE RESIDENT'S BOWEL STATUS PRIOR TO THE ADMINISTRATION OF SENNA AND	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 9 DOCUMENT HER RESPONSE. Give 1 tablet for no bowel movement. Give 2 tablets if no bowel movement. Give 3 tablets if no bowel movement in 8 hrs [hours]. Give 4 tabs if resident complaint of no bowel movement within the last 48 hrs [hours] (PLEASE RECORD THE NUMBER OF SENNA TABLET (S) YOU HAVE ADMINISTER [sic] ON YOUR SHIFT)" The MAR indicated Senexon S was administered at 8:00 a.m., six times and was refused nine times during the month of September. In addition, the MAR indicated Senexon S was administered on January 1, 2025, at 8:00 a.m. The section for medication notes lacked how many tablets were administered on January 1, 2025. On January 6, 2025, at 12:18 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated Senexon was not covered by R6's insurance and R6 was having loose stools so they have attempted to reach out to the prescriber to discontinue the medication. CNS/RN-A stated they updated the MAR with instructions for ULP to document the number of tablets given in the notes. CNS/RN-A stated they did not have documentation for how many Senenox R6 received on January 1, 2025. Unlicensed personnel (ULP)-Q joined the conversation and stated they signed Senenox was given to R1 on January 1, 2025, however, R6 did not receive the medication and they documented incorrectly by accident. The licensee's undated Documentation of Medication Administration policy indicated medication documentation would include the medication name, dosage, date and time administered, and method and route of administration.	{01760}			

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{01760}	Continued From page 10 No further information was provided.	{01760}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

October 22, 2024

Licensee

Angel's Health & Home Care Services Inc
4213 63rd Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 418161
Health Facility Identification Number (HFID) 35639
Project Number(s) SL35639015 and HL356396349C/HL356394843M

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on September 17, 2024, to determine correction of orders found not corrected during the July 31, 2024, and April 17, 2024, follow-up surveys pursuant to the survey completed on January 25, 2024. In addition, complaint investigation(s) HL356396349C/ HL356394843M completed on October 8, 2024, are being considered in our determination under this enforcement action. Based on the follow-up survey results, including the complaint investigation, you continue to not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

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

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 25, 2024, found not corrected at the time of the September 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8

1290-Background Studies Required-144g.60 Subdivision 1

1730-Individualized Medication Management Plan-144g.71 Subd. 5

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

The details of the violations noted at the time of this follow-up survey completed on September 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 September 17, 2024, and complaint investigation completed on October 8, 2024, we identified the following violation(s):

1530-Training In Dementia Care Required-144g.64

0620 - 144g.42 Subd. 6 (a) / 626.557, Subd. 3 - Compliance With Requirements For Reporting Ma

2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - \$3,000.00

The details of the violation(s) noted at the time of this follow-up survey and complaint investigation completed on October 8, 2024, 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 \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Angel's Health & Home Care Services Inc will not admit

any new residents under its extended conditional assisted living facility license until MDH removes the “no new admissions” condition. Angel's Health & Home Care Services Inc must provide the Department:

- i. A list of the names and birthdates of any individuals Angel's Health & Home Care Services Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.
- ii. A list of all current residents by location including:
 1. Name and birthdate of each resident
 2. Physical location of each resident
 3. Current payment source for services
 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Angel's Health & Home Care Services Inc will continue to contract with an RN to provide consultation concerning all resident(s) to whom Angel's Health & Home Care Services Inc provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Angel's Health & Home Care Services Inc. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Angel's Health & Home Care Services Inc and MDH must review the RN's credentials and approve the selection. Angel's Health & Home Care Services Inc will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to continue to provide guidance to Angel's Health & Home Care Services Inc in an effort to help Angel's Health & Home Care Services Inc align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Angel's Health & Home Care Services Inc will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Angel's Health & Home Care Services Inc and the RN consultant about a change. Each report will continue to be electronically submitted to Casey DeVries, Surveyor Supervisor, State Evaluation Team, Health Regulation Division,

at Casey.DeVries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will continue to include information such as:

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may continue to make unannounced monitoring visits to assess the progress of Angel's Health & Home Care Services Inc to correct the violations cited during the follow-up survey as well as to determine the overall practice of Angel's Health & Home Care Services Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Angel's Health & Home Care Services Inc will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

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

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

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

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/17/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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: SL35639015-3 On September 16, 2024, through September 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 January 25, 2024, and follow-up surveys completed on April 17, 2024, and July 31, 2024. At the time of the survey, there were three residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued/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.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}			
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 2 Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-Q). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-Q was hired on December 28, 2022, to provide direct care services to residents. ULP-Q's record lacked a health history and symptom screening and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On September 17, 2024, at 10:15 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated all employees completed a health history and symptom screening upon hire. CNS/RN-A stated they then have the employee bring in a Mantoux or QuantiFERON gold that was completed within the last 90 days or a chest Xray with documentation of a positive Mantoux history. CNS/RN-A stated the licensee should have record of ULP-Q's Mantoux in the office and they would call the office to look into it. On September 17, 2024, at 1:54 p.m., agent (A)-C stated they did not have ULP-Q's TB	{0 650}			

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{0 650}	Continued From page 3 screening and they sent a query to the providers office that completed TB screenings for the company. A-C stated the company said they could provide the results to the licensee on September 18, 2024. A-C stated, "that is a record we should produce." After the survey was completed A-C called the surveyor via phone and stated they obtained the results for ULP-Q. The CDC's document titled Baseline TB Screening and Testing dated December 15, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. The licensee's undated Tuberculosis Screening policy read, "Each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB skin testing via the Mantoux method." No further information was provided.	{0 650}			
{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	{0 800}			

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{0 800}	Continued From page 4 repair program. This MN Requirement is not met as evidenced by: No further action is required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	{0 810}			

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{0 810}	Continued From page 5 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of ten employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 6 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: The licensee's Survey Corrective Action Plan (CAP) section titled Subdivision 1 Background Check dated September 1, 2024, indicated employees whose background checks were not cleared would be promptly removed from the schedule. Newly hired staff will be required to complete a background study, all competency training and be evaluated prior to providing cares. On September 17, 2024, at 6:40 a.m., the surveyor reviewed the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster for health facility identification number (HFID#) 35639. The surveyor did not observe ULP-D on the roster. The surveyor requested the company wide NETStudy 2.0 roster. On September 17, 2024, at 8:23 a.m., agent (A)-C provided the surveyor with the licensee's corporate umbrella NETStudy 2.0 roster, via email, which contained all HFIDs under the corporate umbrella and the surveyor observed the following background studies completed however, affiliated to the licensee's sister facilities: -ULP-D affiliated to HFID#32874 and HFID#98898 with "Disqualified-Set Aside". On September 17, 2024, at 9:13 a.m., the surveyor observed NETStudy 2.0 and observed	{01290}			

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{01290}	Continued From page 7 an application was submitted for ULP-D for HFID#35639 on May 17, 2024, however, was not completed because of no consent and ULP-D was removed from the licensee's roster on June 1, 2024. The document indicated supervision was required while working at the facility. On September 17, 2024, at 9:05 a.m., A-C stated they attempted to affiliate ULP-D to the HFID#35639 on February 8, 2024, however, NETStudy would not allow it. A-C stated they attempted to run a new background study however, the fingerprints "elapsed". A-C stated they ran a background study on May 17, 2024, and NETStudy did not show it went further than the registry check. A-C stated they did not know why ULP-D became separated from the roster for HFID#35639 on June 1, 2024. On September 17, 2024, at 9:35 a.m., ULP-D stated prior to their schedule change in August they worked by themselves in the facility providing direct care. ULP-D stated after their schedule change, they worked with someone in the facility unless there was a medical appointment, then one ULP would take the resident to the appointment. On September 17, 2024, at 9:45 a.m., ULP-J stated ULP-D worked independently in the home at times. ULP-J stated when they worked with ULP-D there were times one would work in the upper level of the facility and the other would work in the basement of the facility due to frequent requests made by R7. On September 17, 2024, at 10:14 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated ULP-D had worked independently in the facility however, recently ULP-D worked with	{01290}			

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{01290}	Continued From page 8 another ULP. On September 17, 2024, at 1:54 p.m., A-C stated they contacted NETStudy and they confirmed ULP-D was separated from the HFID#35639 roster due to no consent. A-C stated they allowed ULP-D to continue work independently because ULP-D was valid to work at another facility within the company. The licensee's undated Background studies policy indicated the licensee required background screening to be complete on all employees, contractors, and regularly scheduled volunteers. In addition, employees would not be able to start working with resident until the background check clearance had been received by the facility. No further information was provided.	{01290}			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/17/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
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01530	Continued From page 9 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J was hired on February 19, 2024, to provide direct care services to residents. The licensee's staff schedules dated August 2024 and September 2024 indicated ULP-J worked 44 days (352 hours) during the months of August and September.	01530			

Minnesota Department of Health

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01530	Continued From page 10 On September 16, 2024, through September 17, 2024, the surveyor observed ULP-J alone in the facility tending to resident needs and requests. ULP-J's employee record included an EduCare (a training software) transcript which indicated ULP-J completed seven hours and 15 minutes of dementia care training between July 30, 2024, and August 8, 2024. In addition, the document indicated ULP-J completed four and a half hours of dementia care training on September 16, 2024, during the survey. ULP-J's employee record lacked at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. On September 17, 2024, at 10:17 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated dementia care training was completed on EduCare and they knew from the previous surveys all employees need eight initial hours of dementia care training. On September 17, 2024, at 10:36 a.m., agent (A)-C stated the licensee provided staff with five hours of dementia care training within the first 168 hours of employment start date and after they completed the hours and the dementia classes they would assign them an additional three hours of dementia care training. On September 17, 2024, at 1:54 p.m., A-C stated they believed there was a break in dementia care training because ULP-J went on a month leave of absence. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial dementia	01530			

Minnesota Department of Health

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01530	Continued From page 11 care training on required topics within 160 hours from employment start date. In addition, until this training was complete, the employee must not provide direct care unless there was another employee onsite who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if an issue arises. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 12 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an accurate individualized medication management record for each resident to include all required content for one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's Survey Corrective Action Plan	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 13 (CAP) section titled Individualized Medication Management Plan dated September 1, 2024, indicated R7's individualized medication management plan was complete and reviewed with resident and/or family. In addition, the licensee managed and stored all medication to optimize therapeutic outcome and monitoring compliance. R7 admitted to the licensee on May 31, 2024, and began receiving assisted living services. R7's diagnoses included quadriplegia (paralysis that affects all limbs and body from the neck down) myasthenia gravis (neuromuscular disorder that leads to weakness of skeletal muscles), epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors), major depression, opioid dependence, and enterocolitis (inflammation in both intestines at one caused by severe infections). R7's Service Plan (Waiver)-Addendum to Contract signed August 22, 2024, indicated R7 received assistance with bathing, housekeeping, laundry, catheter care, dressing, mobility, grooming, incontinent care, behavior management, meals, medication administration, blood glucose monitoring, positioning, vital signs monitoring, safety checks, and transfer assistance. R7's Med Admin Summary - Month dated September 2024 included ondansetron 4 milligram (mg) tablet dissolve 1-2 tablets by mouth every 12 hours as needed. The order lacked parameters on when to administer 4 mg verses 8 mg of ondansetron.	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 14 R7's Individualized Medication Management Plan dated August 21, 2024, indicated the licensee's staff administered R7's medications, R7 took medication whole, RN (registered nurse) and ULP (unlicensed personnel) were responsible for medication reordering, medications were locked in medication room, ULP were allowed to administer oral medications and inhalers, and staff were to contact the RN with questions or concerns related to medication administration via phone, text, and messages on a blackboard. R7's individualized medication management plan comprised of multiple documents lacked the following required content: - documentation of specific resident instructions relating to the administration of medication; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 16, 2024, at 12:50 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated ondansetron was a new order for R7. CNS/RN-A they did not put parameter instructions in the medication administration record because R7 went to the hospital shortly after receiving the order. CNS/RN-A stated they would normally write the parameters to give one tablet for nausea or vomiting and if the symptoms did not resolve give the second tablet. The licensee's undated Individualized Medication Management Plan and Record policy read the individualized medication management "plan must include the following: a. A statement describing the medication	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 15 management services that will be provided b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided.	{01730}			
{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	{01760}			

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{01760}	Continued From page 16 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately document the dosage of medication that was administered for one of three residents (R6). 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: The licensee's Survey Corrective Action Plan (CAP) section titled Documentation of Administration of Medication dated September 1, 2024, indicated the licensee rephrased administration instructions for the unlicensed personnel (ULP) on the medication administration record (MAR) related to Senexon S. Staff would assess R6's bowel pattern prior to Senexon S administration and document the number of Senexon S tablets administered and R6's response to the bowel medication. In addition, the registered nurse (RN) would review the MAR weekly and ensure the protocol for administration of medications was being followed. R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services.	{01760}			

Minnesota Department of Health

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{01760}	Continued From page 17 R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's Discharge Instructions dated June 17, 2024, included Senexon-S 8.6 milligrams (mg)/ 50 mg take one to four tablets by mouth twice a day for post operation pain and constipation. R6 Med Amin Summary - Month dated September 2024 read "Senexon-S tab 8.6-50 mg (Daily) 1- 4 tablets by mouth twice daily for complaints of no bowel movement. (ASK ABOUT THE RESIDENT'S BOWEL STATUS PRIOR TO THE ADMINISTRATION OF SENNA AND DOCUMENT HER RESPONSE. Give 1 tablet for no bowel movement. Give 2 tablets if no bowel movement. Give 3 tablets if no bowel movement in 8 hrs [hours]. Give 4 tabs if resident complaint of no bowel movement within the last 48 hrs [hours] (PLEASE RECORD THE NUMBER OF SENNA TABLET (S) YOU HAVE ADMINISTER ON YOUR SHIFT)" The MAR indicated Senoxon S was administered at 8:00 a.m., six times and was refused nine times during the month of September. In addition, the MAR indicated Senoxon S was administered at 8:00 p.m., 11 times and was refused four times in the month of September. The MAR contained a section for medication notes and indicated one tablet of Senoxon S was administered on September 6, 2024, however, all other medication notes lacked how many tablets were administered on each time and date Senoxon S was administered.	{01760}			

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{01760}	Continued From page 18 On September 16, 2024, at 12:50 a.m., clinical nurse supervisor/registered nurse (RN)-A stated after the previous survey they added additional notes to the MAR to instruct ULP on how to administer Senoxon S. CNS/RN-A stated Senoxon S required a note in the MAR each time the medication was administered in order for ULP to document Senoxon S was administered. CNS/RN-A stated they trained ULP to document the amount of Senoxon S tablets administered to R6 in the notes section. CNS/RN-A stated they were not sure why ULP did not follow the training or instructions listed on the MAR. The licensee's undated Documentation of Medication Administration policy indicated medication documentation would include the medication name, dosage, date and time administered, and method and route of administration. No further information was provided.	{01760}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

August 9, 2024

Licensee

Angel's Health & Home Care Services Inc
4213 63rd Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 413308
Health Facility Identification Number (HFID) 35639
Project Number(s) SL35639015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on July 31, 2024, to determine orders found not corrected during the April 17, 2024, follow-up survey pursuant to the initial survey completed on January 25, 2024. Based on the follow-up survey results you were found to continue not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 60-day conditional license due to expire on **October 8, 2024**.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 25, 2024, found not corrected at the time of the July 31, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - \$500.00
0340-Correction Orders-144g.30 Subd. 5 - \$3,000.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - \$500.00
0650-Employee Records-144g.42 Subd. 8

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

1370-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (a)

1380-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (b)

1730-Individualized Medication Management Plan-144g.71 Subd. 5

2290-Legislative Intent-144g.91 Subd. 2 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 31, 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 July 31, 2024, we identified the following violation(s):

1060-Emergency Relocation-144g.52 Subd. 9

1690-Medication Management Services-144g.71 Subdivision 1

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

1940-Individualized Treatment Or Therapy Management-144g.72 Subd. 3

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 \$7,500.00**. 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.

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.

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Angel's Health & Home Care Services Inc will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Angel's Health & Home Care Services Inc must provide the Department:

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

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Angel's Health & Home Care Services Inc to correct the violations cited during the follow-up survey as well as to determine the overall practice of Angel's Health & Home Care Services Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Angel's Health & Home Care Services Inc will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

MDH will determine if Angel's Health & Home Care Services Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the extended 60-day conditional license period. If MDH determines Angel's Health & Home Care Services Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Angel's Health & Home Care Services Inc's assisted living facility license, and Angel's Health & Home Care Services Inc will correct any outstanding violations identified during the survey. If Angel's Health & Home Care Services Inc is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

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

Sincerely,

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

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/31/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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: SL35639015-2 On July 30, 2024, through July 31, 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 January 25, 2024, and a follow-up survey completed on April 17, 2024. At the time of the survey, there were three residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued/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

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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: 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). The findings include: During the entrance conference of the initial	{0 250}			

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{0 250}	Continued From page 3 survey on January 22, 2024, at 10:02 a.m., agent (A)-C 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. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	{0 250}			

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{0 250}	Continued From page 4 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 existence of a management agreement or subcontract. - I have examined this application and all	{0 250}			

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{0 250}	Continued From page 5 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-C on July 3, 2023. The licensee had an assisted living license issued on August 1, 2023, with an expiration date of July 31, 2024. On May 14, 2024, the Minnesota Department of Health (MDH) issued the licensee a Conditional License pursuant to surveys concluded on January 25, 2024, and April 17, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; and - medication and treatment management.	{0 250}			

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{0 250}	Continued From page 6 On July 31, 2024, at 3:05 p.m., during the exit conference, A-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0340, 0650, 1060, 1290, 1370, 1380, 1690, 1730, 1760, 1940, and 2290 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}			
{0 340} SS=I	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 electronically. (c) By the correction order date, the facility must document in the facility's records any action taken	{0 340}			

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{0 340}	Continued From page 7 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 survey completed on January 25, 2024, and a follow-up survey completed April 17, 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: On May 14, 2024, the Minnesota Department of Health (MDH) issued the licensee a Conditional License pursuant to surveys concluded on January 25, 2024, and April 17, 2024. On July 30, 2024, at 9:42 a.m., via email, agent (A)-C provided the surveyor the licensee's plan of correction (POC). The licensee's POC read the licensee "respectfully submits this plan of correction and our allegation of non-compliance as of April 23, 2024." The plan had three categories titled correction, education, and audit	{0 340}			

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{0 340}	Continued From page 8 under each of the following correction orders: 0250, 0340, 0460, 0470, 0480, 0485, 0490, 0510, 0630, 0650, 0660, 0680, 0720, 0800, 0810, 0820,0830, 0900, 1290, 1470, 1500, 1530, 1640, 1730, 1760, 1820, 1890, 1910, 1940, and 3090. The plan indicated various corrective measures, education, and audits to be completed by the licensee to come into compliance with state regulations. The surveyor observed previously cited correction orders 1370, 1380, and 2290 were not addressed on the licensee's POC. On July 30, 2024, at 1:13 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated they had corrected clinical orders on the plan of correction and administration worked on the remaining correction orders. On July 31, 2024, the follow-up survey concluded, and the following correction orders were reissued: 0250, 0650, 1290, 1370, 1380, 1730, and 2290. In addition, the following previously cited correction orders from the initial survey completed on January 25, 2024, which were found corrected during the first follow-up survey completed April 17, 2024, were reissued: 1760 and 1940. New correction orders issued were: 1060 and 1690. No further information was provided.	{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	{0 480}			

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{0 480}	Continued From page 9	{0 480}			
{0 650} SS=E	This MN Requirement is not met as evidenced by: No further action is required. 144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (unlicensed personnel (ULP)-A, ULP-B).	{0 650}			

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{0 650}	Continued From page 10 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). The findings include: The licensee's plan of correction (POC) dated April 23, 2024, indicated the administrator would audit new employee files immediately after hire and ensure ULP competency evaluations were complete by auditing the employee record one week after hire. ULP-J ULP-J was hired on February 19, 2024, to provide direct care services to residents. On July 30, 2024, at 9:23 a.m., the surveyor observed ULP- J administer oral medication to R3. ULP-J's record lacked the following required content: - training: - documentation requirements for all services provided; - appropriate and safe techniques in personal hygiene and grooming including care and use of hearing aids; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls;	{0 650}			

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NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
{0 650}	Continued From page 11 - standby assistance techniques and how to perform them; - 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; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; - awareness of commonly used technology equipment and assistive devices; - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motion. - competency evaluations: - range of motion; and - appropriate and safe techniques in personal hygiene and grooming including hair care and bathing, and dressing and assisting with toileting. ULP-N ULP-N was hired on June 28, 2024, and began providing assisted living services. ULP-N's record lacked the following required content: - trainings: - documentation requirements for all services provided; - changes in the resident's condition to the supervisor designated by the assisted living provider;	{0 650}			

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{0 650}	Continued From page 12 - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respiration of resident; and - range of motion and positioning. -competency evaluations: - appropriate and safe techniques in personal hygiene and grooming including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motion ad positioning. On July 31, 2024, at 2:12 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated general assisted living orientation was completed by the administration and they completed the clinical requirements. CNS/RN-A stated they train on all clinical requirements and complete competency evaluations on required tasks.	{0 650}			

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{0 650}	Continued From page 13 CNS/RN-A stated they completed all requirements with ULP-N, and they were unsure if ULP-J completed all of the requirements because it was before they started their current role as CNS with the licensee. CNS/RN-A stated once they complete competency evaluations, they provide them to the company office where they are filed into the employee record. CNS-C stated they were not sure what happened to the trainings and the competency evaluation documents because they were not responsible for filing them. On July 31, 2024, at 2:19 p.m., ULP-N stated they received training and competency evaluations by CNS/RN-A on the topics listed above. On July 31, 2024, at 2:22 p.m., ULP-J stated they received training and competency evaluations by a nurse on the topics listed above. The licensee's undated Personnel Records policy read, "a. The personnel record for an employee shall include, but not be limited to, the following: 1) Evidence of current professional license, registration, or certification 2) Records of orientation to the facility, the license, and employee roles and responsibilities 3) Records of annual training including infection control training and competency evaluations" The policy did not address initial training or competency evaluations. No further information was provided.	{0 650}			
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}			

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{0 800}	Continued From page 14 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: No further action is required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	{0 810}			

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{0 810}	Continued From page 15 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}			
01060 SS=D	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	01060			

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01060	Continued From page 16 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 the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of an emergency relocation greater than four days for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01060			

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01060	Continued From page 17 R7 admitted to the licensee on May 31, 2024, and began receiving assisted living services. R7's Service Plan (waiver)-Addendum to Contract signed June 4, 2024, indicated R7 received assistance with bathing, housekeeping, laundry, catheter care, dressing, mobility, grooming, incontinent care, behavior management, meals, medication administration, blood glucose monitoring, positioning, vital signs monitoring, safety checks, and transfer assistance. R7's Emergency Relocation Notification dated July 22, 2024, indicated R7 was hospitalized on July 21, 2024, for bladder and abdominal pain. R7's emergency relocation notice included the required content. R7 had not returned to the facility from the hospital at the time of the survey. R7's medical record lacked a notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days. On July 31, 2024, at 11:00 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated, "I forgot we were supposed to send it to them." CNS/RN-A stated they updated R7's case worker. The Licensee's Emergency Relocation of Resident policy, dated August 1, 2021, read, "When resident goes to hospital, skilled nursing, or need emergency relocation the following step must be taken: - The notice must be delivered to the resident's case manager if the resident is receiving home and community-based waiver services. - The notice must also be delivered to the Office of Ombudsman for Long Term Care as soon as practicable and within 24 hours if the resident has	01060			

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01060	Continued From page 18 relocated and not returned to the community within four days. - The notice must include the reason for the relocation, the name and contact information for the location and service provider where the resident is being relocated, and the contact information for the Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. - The notice must also include, if known and applicable, the estimated date or date range of when the resident is expected to return to the community. If the date or estimated date is not known, the notice must include a statement that the return date is not known." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of 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.	{01290}			

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{01290}	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of eight employees (clinical nurse supervisor/registered nurse (CNS/RN)-A, unlicensed personnel (ULP)-M, ULP-N, ULP-O). 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 finding include: The licensee's plan of correction (POC) dated April 23, 2024, indicated the licensee completed background studies for CNS/RN-A, ULP-D, ULP-G, ULP-I, and office administrator (OA)-H. New employees would be required to complete a background study prior to providing cares and services. Education was provided to the administrator related to background studies. The administrator would monitor and review new employee's paperwork to ensure a background study clearance was received. CNS/RN-A CNS-C/RN-A was hired on December 12, 2018, to provide supervision to ULP and to provide direct care services to residents.	{01290}			

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{01290}	Continued From page 20 CNS-C was licensed as a registered nurse on September 9, 2014. ULP- M ULP-M was hired on June 6, 2024, to provide direct care services to residents. The licensee's RTasks (a documenting software program) indicated ULP-M clocked in at 3:09 p.m., and clocked out at 10:11 p.m., on July 8, 2024. ULP-N ULP-N was hired on June 28, 2024, to provide direct care services to residents. On July 31, 2024, at 7:44 a.m., ULP-N stated they were the only staff member working on the evening shift on July 29, 2024. ULP-O ULP-O was hired on June 12, 2024, to provide direct care services to residents. On July 30, 2024, at 11:22 a.m., ULP-O stated they arrived for work on July 29, 2024, between 10:15 p.m., and 10:20 p.m., and were the only staff member working in the facility on the overnight shift. On July 31, 2024, at 7:15 a.m., the surveyor reviewed the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster for health facility identification number (HFID#) 35639. The surveyor did not observe ULP-M, ULP-N, or ULP-O on the roster. In addition, the surveyor observed "In Process" for CNS/RN-A's background study. The surveyor requested the company wide NETStudy 2.0 roster.	{01290}			

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{01290}	Continued From page 21 On July 31, 2024, at 7:43 a.m., agent (A)-C provided the surveyor with the licensee's corporate umbrella NETStudy 2.0 roster, via email, which contained all HFIDs under the corporate umbrella and the surveyor observed: - No background study completed for the following employee: - ULP-M - background studies completed affiliated to the licensee's sister facilities: - CNS/RN-A affiliated to HFID# 32874 and read, "eligible-no longer valid"; - ULP-N affiliated to HFID# 36870 and affiliated to the licensee on July 31, 2024, during the survey; - ULP-O affiliated to HFID# 36870 and affiliated to the licensee on July 31, 2024, during the survey. On July 31, 2024, at 7:49 a.m., CNS/RN-A stated ULP-M did not have any other names they were associated with. CNS/RN-A stated ULP-M had not worked at the licensee's facility for a while; however, they were still employed by the licensee. On July 31, 2024, at 8:17 a.m., via email, A-C indicated ULP-M did not have any other names associated with them. On July 31, 2024, at 9:10 a.m., A-C stated background studies were completed by a partial owner to the company. A-C stated after a candidate for employment finished the hiring interview and were recommended for hire by the office manager, who was no longer employed, the partial owner would collect the background study paperwork and then the background study was processed by the partial owner. A-C stated they	{01290}			

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{01290}	Continued From page 22 were not sure why CNS/RN-A, ULP-N, and ULP-O were not affiliated with the licensee's HFID; however, they believed the employees may have been hired for a different location when they initially started with the company, and they were just not affiliated to the new facility when they moved locations. A-C stated they were not sure why ULP-M did not have a background study. A-C stated they believed the background study was initiated however; they missed the consent for finger printing so it was unable to be processed. A-C stated they believed ULP-M was under direct supervision by a ULP or CNS/RN-A while at the facility. On July 31, 2024, at 11:59 a.m., A-C stated ULP-M was still employed however, they had removed ULP-M from the schedule. On July 31, 2024, at 1:09 p.m., ULP-M stated they were an on-call staff member for the licensee. ULP-M stated after they completed training, they had worked in the facility one to two times independently without other staff members being present. ULP-M stated they completed medication administration, made dinner, and completed tasks requested by the residents. The licensee's undated Background Studies policy indicated employees would not be able to start working with residents until the background check clearance had been received. No further information provided.	{01290}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	{01370}			

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{01370}	Continued From page 23 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}			

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{01370}	Continued From page 24 Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (ULP)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's plan of correction (POC) dated April 23, 2024, did not address previously cited correction order number 1370 related to training and evaluation of unlicensed personnel. ULP-J was hired on February 19, 2024, to provide direct care services to residents. On July 30, 2024, at 9:23 a.m., the surveyor observed ULP-J administer oral medication to R3. ULP-J's record lacked the following required content: Training: - appropriate and safe techniques in personal hygiene and grooming including care of teeth, gums, and oral prosthetic devices. Competency evaluations: - appropriate and safe techniques in personal hygiene and grooming including care of teeth, gums, and oral prosthetic devices, and care and	{01370}			

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{01370}	Continued From page 25 use of hearing aids. On July 31, 2024, at 2:22 p.m., ULP-J stated they did not receive training or competency evaluation on oral cares. ULP-J stated they used common sense because instructions were written in RTasks (a documenting software program) on how to perform oral care. ULP-J stated they were provided training on hearing aids on EduCare (a training software program) however, they did not receive a competency evaluation. On July 31, 2024, at 2:12 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated general assisted living orientation was completed by the administration and they completed the clinical requirements. CNS/RN-A stated they train on all clinical requirements and complete competency evaluations. CNS/RN-A stated they were unsure if ULP-J completed all of the requirements because it was before they started their current role as the CNS with the licensee. CNS/RN-A stated once they complete competency evaluations, they provide them to the company office where they are filed into the employee record. The licensee's undated Competency Evaluations policy indicated training and competency evaluations for all ULP must include appropriate and safe techniques in personal hygiene and grooming including: - hair care and bathing; - care of teeth, gums and oral prosthetics; - care and use of hearing aids; and - dressing and assisting with toileting. No further information was provided.	{01370}			

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{01380}	Continued From page 26	{01380}			
{01380} SS=D	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 competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (ULP)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	{01380}			

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{01380}	Continued From page 27 The licensee's plan of correction (POC) dated April 23, 2024, did not address previously cited correction order number 1380 related to training and evaluation of ULP. ULP-J was hired on February 19, 2024, to provide direct care services to residents. On July 30, 2024, at 9:23 a.m., the surveyor observed ULP- J administer oral medication to R3. ULP-J's record lacked the following required content: - training on ambulation; and - competency evaluation on ambulation. On July 31, 2024, at 2:22 p.m., ULP-J stated they did not remember if they were trained or received a competency evaluation on ambulation. On July 31, 2024, at 2:12 p.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated general assisted living orientation was completed by the administration and they completed the clinical requirements. CNS/RN-A stated they train on all clinical requirements and complete competency evaluations. CNS/RN-A stated they were unsure if ULP-J completed all of the requirements because it was before they started their current role as CNS with the licensee. CNS/RN-A stated once they complete competency evaluations, they provide them to the company office where they are filed into the employee record. The licensee undated Competency Evaluations policy indicated training and competency evaluations for all ULP must include safe transfer	{01380}			

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{01380}	Continued From page 28 techniques and ambulation. No further information was provided.	{01380}			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.	01690			

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01690	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement measures to ensure security and accountability for the overall management, control, and disposition of controlled substances in compliance with state and federal regulations. 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: R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's diagnoses included, depression, anxiety disorder, diabetes insipidus, chronic pain syndrome, and other psychoactive substance abuse. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's prescribers orders signed June 20, 2024,	01690			

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01690	Continued From page 30 included oxycodone 5 milligrams (mg) give one to two tablets by mouth every four hours as needed for severe pain. On July 30, 2024, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-J setting up R6's morning oral medication. R6 inquired if their pain medication was delivered from the pharmacy on the evening of July 29, 2024. ULP-J searched the medication closet along with two sealed brown bags with packing slips attached that were delivered from the pharmacy and was unable to find oxycodone 5 mg. R6 called the pharmacy and put the phone on speaker. The surveyor heard an unknown pharmacy worker state the oxycodone was delivered on July 29, 2024, and was signed by ULP-O. ULP-J stated they were contacting the registered nurse (RN) and the employees who worked last evening. R6 reported their pain level at an eight and a half or nine out of ten. The surveyor did not observe any nonverbal signs of pain. On July 30, 2024, at 9:39 a.m., clinical nursing supervisor/registered nurse (CNS/RN)-A stated they were aware of the narcotics missing and they were attempting to get ahold of the staff members that worked on July 29, 2024. On July 30, 2024, at 9:43 a.m., the surveyor observed ULP-J update CNS/RN-A on R6's pain rating. On July 30, 2024, at 9:51 a.m., CNS/RN-A stated there were unable to locate R6's oxycodone in the facility and they would start an incident report. On July 30, 2024, at 10:15 a.m., ULP-J inquired what R6's pain level was at. R6 stated it was an eight and a half or nine out of ten. ULP-J	01690			

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01690	Continued From page 31 suggested R6 take an as needed (PRN) Tylenol or go to the hospital due to the high pain rating. R6 declined all interventions recommended by ULP-J for pain. On July 30, 2024, at 10:22 a.m., CNS/RN-A stated the pharmacy said the oxycodone was delivered on July 29, 2024, at 9:45 p.m., and was signed by ULP-O. CNS/RN-A stated at the time the medication was delivered ULP-O was not at work and ULP-N was on shift. CNS/RN-A stated the pharmacy driver delivered the medication to R3 because they thought R3 was a staff member. CNS/RN-A stated R3 told the pharmacy delivery driver they were ULP-O and signed as ULP-O. CNS/RN-A stated R3 brought two bags into the facility and "apparently he took the narcotic. I questioned [R3]." CNS/RN-A stated R3 told them he did receive the medication from the driver, and he put three brown bags on the kitchen table. CNS/RN-A stated there was "suspicious activity" as R3 and R6 left the facility at 3:00 a.m. and returned at 4:00 a.m., on July 30, 2024. CNS/RN-A stated they contacted the prescriber and the prescriber stated they would not refill the prescription for lost or stolen narcotics because R6 was six weeks post operative. CNS/RN-A stated the licensee had a medication delivery policy however, the ULP were unable to follow it because R3 took the medication and ULP-N was unable to talk to the delivery driver. On July 30, 2024, at 10:33 a.m., R6 refused an interview with the surveyor. On July 30, 2024, at 10:34 a.m., R3 stated the pharmacy delivery driver asked them if their name was [ULP-O]. R3 stated they told the delivery driver no. R3 stated they were outside with R6 when the delivery occurred and the staff	01690			

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01690	Continued From page 32 member who was male was sleeping on the living room couch. R3 stated the pharmacy delivery driver gave them three brown bags, and they placed the three brown bags that contained medications on the kitchen table and then went to their room. R3 stated R6 went to the bathroom after the medications were placed on the kitchen table. The surveyor inquired if the pharmacy delivery driver asked their name. R3 stated no. The surveyor inquired where R3 and R6 went at 3:00 a.m. R3 stated they both went to R6's fiancés because R6's fiancé had an argument with their roommate, and they went to help with the situation and then returned back to the facility. On July 30, 2024, at 11:13 a.m., pharmacist (P)-P stated 28 tablets of oxycodone were delivered on June 29, 2024, at 9:45 p.m., signed on a paper form by ULP-O. On July 30, 2024, at 11:22 a.m., ULP-O stated they called the facility to tell them they were going to arrive late to their shift, and they arrived at the facility between 10:15 p.m. and 10:20 p.m., on July 29, 2024. ULP-O stated ULP-N received medications on their shift and did not log them into the system as they were trained to. ULP-O stated they refused to sign in the medications because they did not receive them from the pharmacy driver. On July 30, 2024, at 11:29 a.m., ULP-N stated they were at the facility when the medications were delivered however, they did not receive the medications from the delivery driver. ULP-N stated they were documenting in the living room at 9:45 p.m., on July 29, 2024, as their shift was almost complete. ULP-N stated the doorbell never rang nor did anyone knock at the door. ULP-N stated R3 brought in from the outside two	01690			

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01690	Continued From page 33 brown bags of medications. ULP-N stated R3 had been sitting outside the entire evening until they brought in the two medication bags. On July 30, 2024, at 11:40 a.m., ULP-N stated they were trained that when medications were delivered from pharmacy they would sign for the medication and put them into the medication closet. ULP-N stated this was their first-time they received medication at the facility since the start of their employment. ULP-N stated they did not open the two brown bags of medications because they were not sure what to do with the medication bags. ULP-N stated they did not want to attempt to complete a task that they did not know how to complete. On July 30, 2024, at 12:23 p.m., the surveyor attempted to contact the pharmacy to interview the delivery driver. The surveyor left a voice message for the supervisor of the drivers, however, did not receive a call back. On July 31, 2024, at 2:46 p.m., CNS/RN-A stated ULP were trained when medications were delivered to sign for the medication, log into RTasks (a documenting software program) and log the medication and quantity that was received, and to call a nurse. CNS/RN-A stated ULP-N was trained on how to handle a pharmacy delivery. CNS/RN-A stated ULP-N did not inform them of the pharmacy delivery and did not document on the medications received in RTasks. The licensee's undated Medication: Controlled Substances policy read, "a. When the pharmacy delivers a prescribed controlled substance/Schedule II medication for a resident who lives in an assisted living facility, the licensed nurse and the pharmacy delivery person will	01690			

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01690	Continued From page 34 count the medication together and will both sign that the correct amount of medication has been delivered. If the count is inconsistent with the prescription label, the nurse will immediately call the pharmacy and will not accept delivery of the prescription. b. The licensed nurse accepting the delivery will put the controlled substances/Schedule II medications in a locked compartment separate from containers for non-controlled medications either in the central medication storage area, if appropriate, or in a locked compartment in the resident's room. The locked compartment for controlled medications must be permanently affixed to the physical plant or to the medication cart." In addition, if controlled drugs were missing, the registered nurse (RN) would investigate and try to determine when drugs went missing and who may have been involved. Depending on circumstances and investigation, the RN or assisted living director (LALD) would decide if appropriate to contact the police and/or common entry point (CEP)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	{01730}			

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{01730}	Continued From page 35 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an accurate individualized medication management record for each resident to include all required	{01730}			

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{01730}	Continued From page 36 content for two of three residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: The licensee's plan of correction (POC) dated April 23, 2024, indicated individualized medication management plans would be reassessed by nursing to ensure compliance every 90 days and with change of condition. R6 R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's diagnoses included, depression, anxiety disorder, diabetes insipidus, chronic pain syndrome, and other psychoactive substance abuse. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's Med Amin Summary - Month dated July	{01730}			

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{01730}	Continued From page 37 2024 included Senoxon-S 8.5 milligrams (mg)/50 mg tablet give one to four tablets by mouth twice per day. The order lacked parameters on when ULP were to administer one tablet, two tablets, three tablets, or four tablets. R6's Individualized Medication Management Plan dated June 17, 2024, indicated ULP and registered nurse (RN) administered R6's medications, RN was responsible for medication ordering, medications would be kept in a medication room, ULP were allowed to administer oral and topical medications, staff were to contact the RN with questions or concerns related to medication administration via phone, text, and messages on a blackboard. R7 R7 admitted to the licensee on May 31, 2024, and began receiving assisted living services. R7's diagnoses included quadriplegia (paralysis that affects all limbs and body from the neck down) myasthenia gravis (neuromuscular disorder that leads to weakness of skeletal muscles), epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors), major depression, opioid dependence, and enterocolitis (inflammation in both intestines at one caused by severe infections). R7's Service Plan (waiver)-Addendum to Contract signed June 4, 2024, indicated R7 received assistance with bathing, housekeeping, laundry, catheter care, dressing, mobility, grooming, incontinent care, behavior management, meals, medication administration, blood glucose monitoring, positioning, vital signs monitoring, safety checks, and transfer assistance.	{01730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/31/2024
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{01730}	Continued From page 38 R7's Med Admin Summary - Month dated July 2024 included ondansetron 4 mg tablet dissolve 1-2 tablets by mouth every 12 hours as needed. The order lacked parameters on when to administer 4 mg verses 8 mg of ondansetron. R7's Individualized Medication Management Plan dated June 4, 2024, indicated the licensee's staff administered R7's medications, R7 took medication whole, RN and ULP were responsible for medication reordering, medications where locked in medication room, ULP were allowed to administer oral medications and inhalers, and staff were to contact the RN with questions or concerns related to medication administration via phone, text, and messages on a blackboard. R6 and R7's individualized medication management plan comprised of multiple documents lacked the following required content: - documentation of specific resident instructions relating to the administration of medication; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On July 31, 2024, at 11:17 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A verified R6 and R7's orders listed above lacked specific resident instructions related to the administration of medication. CNS/RN-A stated R6's Senexon-S was transcribed into the MAR as the prescriber wrote the order. CNS/RN-A stated they called the licensee's pharmacy see how the medication should be administered and the pharmacy stated it was up to the resident on how they wanted to	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 39 take the medication. CNS/RN-A stated they believed R7's order for ondansetron changed prior to a hospitalization and they would ensure parameters were going to be added to the order. The licensee's undated Individualized Medication Management Plan and Record policy read the individualized medication management "plan must include the following: a. A statement describing the medication management services that will be provided b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided.	{01730}			
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	01760			

Minnesota Department of Health

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01760	Continued From page 40 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately document the dosage of medication that was administered for one of two residents (R6). 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: The licensee's plan of correction (POC) dated April 23, 2024, indicated education was provided on medication documentation and included staff to document the name of the medication, the amount prescribed, the date and time medication was given, and the method and path of administration.	01760			

Minnesota Department of Health

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01760	Continued From page 41 R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's Discharge Instructions dated June 17, 2024, included Senexon-S 8.5 milligrams (mg)/ 50 mg take one to four tablets by mouth twice a day for post operation pain and constipation. R6 Med Amin Summary - Month dated July 2024 indicated Senexon-S 8.6mg/50 mg one through four tablets was administered 17 days at 8:00 a.m., and administered 28 days at 8:00 p.m., in the month of July. The medication administration record (MAR) lacked how many tablets were administered on each time and date. On July 31, 2024, at 11:17 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A verified R6's record lacked the number of tablets administered on each date. CNS/RN-A stated R6's Senexon-S was transcribed into the MAR as the prescriber wrote the order. CNS/RN-A stated they called the licensee's pharmacy see how the medication should be administered and the pharmacy stated it was up to the resident on how they wanted to take the medication. The licensee's undated Documentation of Medication Administration policy indicated medication documentation would include the medication name, dosage, date and time	01760			

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01760	Continued From page 42 administered, and method and route of administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be 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	01940			

Minnesota Department of Health

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01940	Continued From page 43 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R6) who received treatments. 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: The licensee's plan of correction (POC) dated April 23, 2024, indicated all resident's individualized treatment and therapy management plans would be complete and include documentation of specific residents instructions relating to the treatments or therapy administration, identification of treatment or therapy tasks that would be delegated to ULP, procedures for notifying the RN or appropriate licensed health professional, and if the prescribed treatment is a piece of equipment, it will be stored in the resident's room. R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's diagnoses included, depression, anxiety	01940			

Minnesota Department of Health

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01940	Continued From page 44 disorder, diabetes insipidus, chronic pain syndrome, and other psychoactive substance abuse. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's prescriber orders dated June 20, 2024, included blood glucose monitoring two times per day. R6's Individualized Treatment and Therapy Plan dated July 30, 2024, indicated R6 received blood glucose monitoring twice per day by ULP. ULP should wear gloves, follow facility protocol, and record blood glucose. Nurse would monitor and update prescriber. The document also indicated, "notify nurse" with nothing written after the statement. R6's individual treatment plan lacked procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On July 31, 2024, at 11:22 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated there were no parameters for the ULP to contact a licensed health professional because the prescriber did not write an order and because they were monitoring blood glucose due to a potential medication side effect. CNS/RN-A stated R6 did not receive any insulin or antidiabetic oral medications.	01940			

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01940	Continued From page 45 The licensee's undated Treatment and Therapy Management Plan policy read, "When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented f. Frequency of supervision of personnel providing the delegated treatment or therapy services g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions h. The treatment or therapy plan will be updated when there are changes i. The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Minnesota Department of Health

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{02290}	Continued From page 46	{02290}			
{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 interview and record review, the licensee limited the rights of residents when the licensee required residents who resided in the facility to follow a behavior contract for two of three residents (R6, R7) and lease addendum for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction (POC) dated April 23, 2024, did not address previously cited correction order number 2290. R3 R3 admitted to the licensee on October 22, 2023, and began receiving assisted living services. R3's Service Plan (Waiver)-Addendum to Contract signed July 11, 2024, indicated R3 received assistance with bathing reminders,	{02290}			

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{02290}	Continued From page 47 behavior management, dressing assistance, grooming reminders, housekeeping, laundry, medication management, vital sign monitoring, and cognitive and mental health needs. R3's record did not include any documentation to indicate the resident and/or their responsible party had requested or agreed the resident should not consume or possess alcohol in the facility as a person-centered safety intervention. R3's record included a Lease Addendum for Crime-Free Alcohol/Beer/Illegal Drug-Free Housing signed September 23, 2023. The document indicated no alcohol was permitted on the premises and if there was it would be a violation of the lease and good cause for termination of tenancy. R3's record did not include a statement that this part of the lease agreement was no longer valid. R6 R6 admitted to the licensee on May 15, 2024, and began receiving assisted living services. R6's Service Plan (Waiver) -Addendum to Contract signed July 11, 2024, indicated R6 received assistance with bathing, behavior management, dressing, grooming, laundry, housekeeping, meals, medication management, blood glucose monitoring, vital signs monitoring, safety checks, shopping assistance, and toileting assistance. R6's record did not include any documentation to indicate the resident and/or their responsible party had requested or agreed the resident should not consume or possess alcohol in the facility as a person-centered safety intervention.	{02290}			

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{02290}	Continued From page 48 R6's Behavior Contract signed by R6 and agent (A)-C on May 15, 2024, indicated the licensee had a zero tolerance for any alcohol use on the licensee's property and anyone including visitors violating the zero-tolerance policy will be asked to leave the premises immediately. In addition, if the agreement was not followed it would be a violation and the licensee could terminate the lease and service agreements. R7 R7 admitted to the licensee on May 31, 2024, and began receiving assisted living services. R7's Service Plan (waiver)-Addendum to Contract signed June 4, 2024, indicated R7 received assistance with bathing, housekeeping, laundry, catheter care, dressing, mobility, grooming, incontinent care, behavior management, meals, medication administration, blood glucose monitoring, positioning, vital signs monitoring, safety checks, and transfer assistance. R7's record did not include any documentation to indicate the resident and/or their responsible party had requested or agreed the resident should not consume or possess alcohol in the facility as a person-centered safety intervention. R7's Behavior Contract signed on May 31, 2024, indicated the licensee had a zero tolerance for any alcohol use on the licensee's property and anyone including visitors violating the zero-tolerance policy will be asked to leave the premises immediately. In addition, if the agreement was not followed it would be a violation and the licensee could terminate the lease and service agreements. On July 31, 2024, at 11:22 a.m., clinical nurse	{02290}			

Minnesota Department of Health

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{02290}	Continued From page 49 supervisor/registered nurse (CNS/RN)-A stated they remembered from the previous survey that residents had to the right to bring and consume alcohol at the facility. CNS/RN-A stated, "certain things beyond clinical I can't control, that is administration." On July 31, 2024, at 3:05 p.m., A-C stated they do not restrict alcohol use because the residents were adults. A-C stated they have not enforced the contract/lease addendum in a year and a half because it was not within the person-centered approach. A-C stated they would communicate to the residents the contract/lease addendum was no longer applicable and remove the documents from the resident's charts. The licensee's undated Assisted Living Bill of Rights indicated the licensee's staff may not request nor obtain from the resident any waiver of any of their rights. No further information was provided.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

May 14, 2024

Licensee

Angel's Health & Home Care Services Inc
4213 63rd Avenue North
Brooklyn Center, MN 55429

RE: Conditional License Number 413308
Health Facility Identification Number (HFID) 35639
Project Number(s) SL35639015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on April 17, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **August 12, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

St - 0 - 0250 - 144G Subdivision 1 - Conditions - \$500.00
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$500.00
St - 0 - 0485 - 144g.41 Subdivision 1. (13)(i)(a)and(c) - Minimum Requirements
St - 0 - 0490 - 144g.41 Subd 1 (13) (ii)-(vii) - Minimum Requirements - \$500.00
St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma
St - 0 - 0650 - 144g.42 Subd. 8 - Employee Records - \$500.00
St - 0 - 0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - \$500.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment
St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) - Fire Protection And Physical Environment - \$500.00
St - 0 - 0900 - 144g.50 Subdivision 1 - Contract Required
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$500.00
St - 0 - 1470 - 144g.63 Subd. 2 - Content Of Required Orientation
St - 0 - 1530 - 144g.64 - Training In Dementia Care Required - \$500.00
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - \$500.00
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan
St - 0 - 1820 - 144g.71 Subd. 13 - Prescriptions - \$500.00
St - 0 - 1890 - 144g.71 Subd. 20 - Prescription Drugs
St - 0 - 3090 - 144.6502, Subd. 8 - Notice To Visitors

The details of the violations noted at the time of this follow-up survey completed on April 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 April 17, 2024, we identified additional violation(s). MDH may assess fines based on the level and scope of the orders outlined below. The total amount of potential fine that may be assessed related to these correction orders is \$500.00.

MDH is not imposing the fine against your provisional license at this time:

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

0720-Access To Records-144g.43 Subd. 2

1370-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (a)

1380-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (b)

2290-Legislative Intent-144g.91 Subd. 2

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 \$5,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Angel's Health & Home Care Services Inc will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Angel's Health & Home Care Services Inc must provide the Department:
 - i. A list of the names and birthdates of any individuals Angel's Health & Home Care Services Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager

5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

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

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

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

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

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

REQUESTING A HEARING:

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

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

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

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

Sincerely,

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

Maria King, RN
Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/17/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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: SL35636015-1 On April 15, 2024, through April 17, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 25, 2024. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. As a result of the revisit, the following orders were issued/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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on 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). The findings include: During the entrance conference during the initial survey on January 22, 2024, at 10:02 a.m., agent	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 3 (A)-C 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. - 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	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 4 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 existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 5 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-C on July 3, 2023. The licensee had an assisted living license issued on August 1, 2023, with an expiration date of July 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On April 17, 2024, at 8:55 a.m., A-C, licensed	{0 250}			

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{0 250}	Continued From page 6 assisted living director/licensed practical nurse (LALD/LPN)-K, and clinical nurse supervisor/registered nurse (CNS/RN)-A confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0340, 0470, 0485, 0490, 0630, 0650, 0660, 0680, 0720, 0800, 0810, 0900, 1290, 1370, 1380, 1470, 1530, 1640, 1730, 1820, 1890, 2290, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{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 electronically. (c) By the correction order date, the facility must	0 340			

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0 340	Continued From page 7 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 interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on January 25, 2024. 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 April 15, 2024, at 10:14 a.m., via email, agent (A)-C provided the surveyor the licensee's plan of correction. The licensee's plan of correction dated January 30, 2024, read the licensee "respectfully submits this plan of correction and our allegation of non-compliance as of January 30, 2024." The plan had three categories titled correction, education, and audit under each of the following orders: 0250, 0460, 0470, 0480, 0485, 0490, 0510, 0630, 0650, 0660, 0680, 0780, 0800, 0810, 0820,0830, 0900, 1290, 1470, 1500, 1530, 1640,	0 340			

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0 340	Continued From page 8 1730, 1760, 1820, 1890, 1910, 1940, and 3090. The plan indicated various corrective measures, education, and audits to be completed by the licensee to come into compliance with state regulations. On April 17, 2024, the revisit survey concluded, and the following orders were reissued 0250, 0470, 0485, 0490, 0630, 0650, 0660, 0680, 0800, 0810, 0900, 1290, 1470, 1530, 1640, 1730, 1820, 1890, and 3090. In addition to the orders reissued, the following orders were issued: 0720, 1370, 1380, and 2290. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the action items the licensee indicated they in their plan of correction were not completed. A-C stated as for implementation of the plan of correction "some were done, and others still have not been done." A-C stated, they created the correction plan and "immediate ones (orders) should have been corrected." The surveyor explained the immediate orders were corrected however, the other orders issued were not. A-C stated the contracts, and the service plans were signed however, they were unable to locate the documents. A-C stated the electronic monitoring sign was made however, they were not sure why it was not posted at the facility. A-C stated they would have to look into why certain parts of the plan of correction were not implemented to give the surveyor a conclusive answer. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated the licensee had multiple departments in the company and each department was responsible for their portion of the plan of correction. LALD/LPN-K stated the departments were in the process of "coming together" to make sure everything on the plan of correction made sense however, their meeting	0 340			

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0 340	Continued From page 9 was cancelled last week, and they did not get to it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	{0 470}			

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{0 470}	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of four residents. The licensee's plan of correction dated January 30, 2024, indicated the following: - the facility had created and put into action a staffing plan with written details, which involved an assessment conducted by the clinical nurse supervisor (CNS); - the clinical and administrative teams were educated on the significance of developing a staffing plan for the facility; and - the clinical nurse will review the staffing plan on a biannual basis. The licensee's Staffing Plan effective date August 1, 2022, included a graph which indicated one	{0 470}			

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{0 470}	Continued From page 11 staff member was scheduled, one staff member was on call, and one manager or registered nurse was on call 24 hours per day seven days per week for the facility. The staffing plan indicated the schedule was able to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's assessments, was evaluated last on August 1, 2023, and indicated the next evaluation of June 31, 2024. The Staffing plan did not include names of who created the Staffing Plan. The Staffing Plan lacked evidence an evaluation was completed by the CNS to ensure staffing levels were adequate to address: A. each resident's needs, as identified in the resident's service plan and assisted living contract; B. each resident's acuity level, as determined by the most recent assessment or individualized review; C. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; D. whether the facility has a secured dementia care unit; and E. staff experience, training, and competency. On April 16, 2024, at 12:01 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated a group of people from the corporate office created the staffing plan and they believed the staffing plan should be evaluated once per year. LALD/LPN-K stated they were unaware the staffing plan needed to be evaluated twice per year by a CNS. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated	{0 470}			

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{0 470}	Continued From page 12 they did not assist with the staffing plan, and it was completed by a "committee". CNS/RN-A stated the staffing plan should be evaluated twice per year. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the items the licensee indicated they completed on the plan of correction were not completed. Agent (A)-C stated as for implementation of the plan of correction "some were done, and others still have not been done." A-C stated they would have to look into why certain parts of the plan of correction were not implemented to give the surveyor a conclusive answer. LALD/LPN-K stated the licensee had multiple departments in the company and each department was responsible for their portion of the plan of correction. LALD/LPN-K stated the departments were in the process of "coming together" to make sure everything on the plan of correction made sense however, their meeting was cancelled last week, and they did not get to it. The licensee's Staffing policy dated August 1, 2022, indicated the staffing plan to determine the required staffing level was prepared by the CNS. No further information was provided.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}			

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{0 480}	Continued From page 13 This MN Requirement is not met as evidenced by: No further action is required.	{0 480}			
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for three of three residents (R1, R4, R3). This had the potential to affect all current and future residents of the facility. This practice resulted in a level one violation (a	{0 485}			

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{0 485}	Continued From page 14 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: The licensee's plan of correction dated January 30, 2024, included the following: - the licensee's contract had been revised and included clear details about the options for residents not to participate in the meal plan; - education was provided to administration and clinical team related to the facility's ability to provide three meals and snacks to residents upon admission and the opportunity to opt out of the meal plan; and - the administrator would conduct an audit of the contract agreement following admissions of a resident and ensure all required contents were met and compliance was achieved. R1 R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's Service Plan (Wavier) - Addendum to Contract signed April 16, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. R1's Resident Contract for Assisted Living signed December 6, 2023, page 13 included:	{0 485}			

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{0 485}	Continued From page 15 "This Assisted Living Facility offers all of the following (included in the Month Base Fee): - At least three meals daily with snacks available seven (7) days per week." The licensee's Resident Contract for Assisted Living lacked the option to opt out of the meal plan. R4 R4 admitted to the licensee on October 15, 2023, and began receiving assisted living services. R4 previously discharged from the current licensee and transferred to a sister facility of the licensee (different Health Facility Identification Number (HFID)) and readmitted to the licensee on October 15, 2023. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of April 16, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's record included a document titled Resident Agreement signed August 1, 2021, provided to R4 by the licensee on a previous admission. R4's record lacked a current written contract with the required content provided by licensee upon re-admission. Page 3 of the Resident Agreement document included: "All the services listed below are included in your Monthly Base Fee ("Included Services"): - Utilities (heat, air conditioning, electricity, water and garbage removal) - Basic cable television - Wireless internet access	{0 485}			

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{0 485}	Continued From page 16 - Local telephone service in common areas - Three meals per day". R4's Resident Agreement lacked the option to opt out of the meal plan. R3 R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract signed April 16, 2024, indicated R3 received assistance with bathing reminder, behavior management, dressing, grooming reminder, housekeeping, laundry, vital sign monitoring, and medication administration On April 15, 2024, through April 17, 2024, on multiple occasions, the surveyor requested R3's signed contract that was completed prior to the survey from the licensee. The surveyor did not receive R3's signed contract throughout the survey and was unable to verify R3's contract did not require R3 to pay for meals as a part of their assisted living package fee. On April 16, 2024, at 10:11 a.m., the surveyor observed licensed assisted living director/licensed practical nurse (LALD/LPN)-K bring three new resident contracts into the facility for R1, R3, and R4. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated, "when I get back, we will have to have them sign the new contract." The surveyor asked if they had signed a new contract since the last survey. CNS/RN-A stated they had not signed another contract. The surveyor inquired why the residents had not received another contract since the plan of correction indicated the licensee had updated the contract. CNS/RN-A stated they didn't know	{0 485}			

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{0 485}	Continued From page 17 and that would be a question for agent (A)-C. On April 16, 2024, at 1:40 p.m., A-C stated a previous house manager had all the residents at the facility sign a new contract when the licensee updated their contract after the previous survey, but they were unable to locate the documents in the corporate office. The licensee's undated Assisted Living Contracts policy indicated the assisted living facility (ALF) require that three meals and snacks be made available and state the facility cannot require a resident to include and pay for meals in their contract. No further information was provided.	{0 485}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates	{0 490}			

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{0 490}	Continued From page 18 opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents who received 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - the licensee developed a daily calendar of programs of social and recreation activities based on resident's preferences and residents were included in the activities calendar planning; - the licensee would ensure a social and recreation activities calendar was available for clients [resident's] daily; - education was proved to staff on the importance of providing social and recreational activities for residents; - education was provided on staff involvement in daily activities; and	{0 490}			

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{0 490}	Continued From page 19 - administrator to ensure the activity Calander was developed and posted monthly in the common area and delivered to residents. On April 15, 2024, through April 17, 2024, the surveyor did not observe any activities offered to the residents. Residents remained in their rooms, in common living area, outside, or in the kitchen. On April 15, 2024, at 9:55 a.m., during facility tour, the surveyor did not observe a daily activity calendar posted in the facility. On April 15, 2024, at 10:01 a.m., unlicensed personnel (ULP)-J stated there was a gaming system at the facility that they would play with residents upon request. The surveyor inquired if the licensee had one activity daily for residents to participate in. ULP-J stated no. The surveyor inquired if they did any other activities besides the gaming system. ULP-J stated no. On April 15, 2024, at 12:14 p.m., R1 stated the licensee did not offer activities however, stated they would not participate in activities if they did. On April 15, 2024, at 1:30 p.m., R3 stated the licensee did not provide them with a schedule for a daily activity. The surveyor inquired if the licensee offered R3 a daily activity since the last survey. R3 stated no, however, "they tried one time to play bingo." On April 16, 2024, at 8:35 a.m., the surveyor inquired if the licensee provided a daily activity. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated, "so this house, they are pretty much independent." CNS/RN-A stated they tried to offer card games, movie night, trivia games, or take the residents on an outing.	{0 490}			

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{0 490}	Continued From page 20 CNS/RN-A stated the licensee was working on a schedule for activities, but they did not have one yet. On April 16, 2024, at 3:01 p.m., ULP-F stated they assisted with activities upon resident request. No further information was provided.	{0 490}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	{0 630}			

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{0 630}	Continued From page 21 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's plan of correction dated January 30, 2024, indicated R1, R3, and R4's IAPP were created and provided detailed guidance on behavior monitoring, preventative action, monitoring frequency, and staff intervention execution as outline on the behavior care plan. R4's diagnoses include diabetes mellitus type 2, chronic kidney disease stage 3 (kidney failure), chronic pain (ongoing pain), osteoarthritis of the right knee (tissues breakdown in the joint), depression with anxiety, degenerative disc disease, and hypertension. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of April 16, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's IAPP dated January 25, 2024, indicated R4 was at risk to abuse other vulnerable adults, however, did not include the following required content: - the person's risk of being abused by other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	{0 630}			

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{0 630}	Continued From page 22 On April 16, 2024, at 8:40 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated R4 was not at risk to be abused. CNS/RN-A stated she forgot to check the box in the RTasks (a documenting software program) IAPP assessment. The surveyor observed CNS/RN-A change R4's IAPP to reflect R4 was not at risk for being abused. CNS/RN-A stated it was "human error." The licensee's undated Abuse Prevention Plan policy read "All residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults". No further information was provided.	{0 630}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	{0 650}			

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{0 650}	Continued From page 23 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-F, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - registered nurse (RN)-A, ULP-B and ULP-E have completed required trainings and competencies; - newly hired staff would be required to complete background studies, all competency trainings, and be evaluated before providing care services; - list of new hires to be submitted to nursing to	{0 650}			

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{0 650}	Continued From page 24 start immediate training and competencies before floor orientation; - education provided to all RN's regarding training and competencies completed during orientation and evaluations for delegated tasks after orientation; and - administrator to audit new employee file immediately after hired and make sure they are up to date on competencies and evaluation of delegated tasks by reviewing employment record after one week hired. On April 15, 2024, at 11:10 a.m., agent (A)-C stated ULP-B and ULP-E had resigned from their positions at the facility, and the licensee did not finish the corrections from the previous survey with their employee record prior to the end of their employment. From April 15, 2024, through April 17, 2024, on multiple occasions, the surveyor requested ULP-F and ULP-J's full employee record including trainings and competencies. ULP-F ULP-F was hired on September 29, 2023, to provide direct cares and services. On April 17, 2024, the surveyor observed ULP-F administer oral medications to R1. ULP-F's record lacked the following: - training: - documentation requirement for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - stand by assistance techniques and how to perform;	{0 650}			

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{0 650}	Continued From page 25 - 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; - recognizing physical, emotional cognitive, and developmental needs of the resident; - observation, reporting, and documenting client status; - safe transfer techniques and ambulation; and - setting up medications for an unplanned time away from home. -competency: - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; - medication administration on all route procedures; and - setting up medications for an unplanned time away from home. On April 17, 2024, at 7:54 a.m., ULP-F stated they received the training listed above and received a competency evaluation from the licensee's previous clinical nurse supervisor. ULP-J ULP-J was hired on March 19, 2024, to provide direct cares and services. On April 16, 2024, at 7:56 a.m., the surveyor observed ULP-J administer oral medications to	{0 650}			

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{0 650}	Continued From page 26 R3. ULP-J's record lacked the following: -orientation: - overview of assisted living statues; - review of providers policies and procedures; - handling emergencies and using emergency services; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - principles of person-centered planning/service delivery. -training: - documentation requirement for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting; - procedures to utilize handling various emergency situations; and - observation reporting and documenting resident status. -competency: - medication administration on all route procedures; and - setting up medications for an unplanned time away from home. On April 15, 2024, at 10:12 a.m., ULP-J stated they were trained on medication administration including as needed (PRN) medications and	{0 650}			

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{0 650}	Continued From page 27 narcotics, the facility's day to day tasks, getting residents up, housekeeping, making medical appointments, documenting in RTasks (a documenting software program), and all orientation of required content. On April 15, 2024, at 1:14 p.m., ULP-J stated they were trained in infection control. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the items the licensee indicated they completed on the plan of correction were not completed. A-C stated as for implementation of the plan of correction "some were done, and others still have not been done." A-C stated, they created the correction plan and "immediate ones (orders) should have been corrected." The surveyor explained the immediate orders were corrected however, the other orders issued were not. A-C stated they would have to look into why certain parts of the plan of correction were not implemented to give the surveyor a conclusive answer. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated the licensee had multiple departments in the company and each department was responsible for their portion of the plan of correction. LALD/LPN-K stated the departments were in the process of "coming together" to make sure everything on the plan of correction made sense however, their meeting was cancelled last week, and they did not get to it. Additionally, LALD/LPN-K stated there were employee record contents stored in an off-site secured storage, paid for by insurance, after a fire that occurred in June 2023 at the corporate office. LALD/LPN-K stated they may need 24 hours to access the records. The surveyor observed the licensee's employee list and noted both employees requested were hired after the fire occurred in the corporate office.	{0 650}			

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{0 650}	Continued From page 28 The licensee's undated Employee Records policy read, "1. Employee records must include the following information: a. Evidence of current professional licensure, registration, or certification if licensure, registration or certification is required b. Records of orientation, required annual training, infection control training and competency evaluations c. Current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision d. Documentation of annual performance reviews that identify areas of improvement needed and training needs e. For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those screenings; and f. Documentation of the background study as required under section 144.057." No further information provided.	{0 650}			
{0 660} SS=D	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	{0 660}			

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{0 660}	Continued From page 29 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility TB risk assessment form dated July 1, 2023, indicated the facility was at a low risk for TB transmission. In addition, agent (A)-C was responsible for maintaining the TB screening records. The licensee's plan of correction dated January 30, 2024, included the following: - ULP-B and ULP-E completed a two-step	{0 660}			

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{0 660}	Continued From page 30 Mantoux or a QuantiFERON gold and a health and history symptom screen and it was placed into the employee record; - education related to TB screening was provided to human resources, and audits on newly hired employees; and - administrator to audit new employee files for TB requirements immediately after hired. On April 15, 2024, at 11:10 a.m., the surveyor requested ULP-B and ULP-E's employee records. Agent (A)-C stated they no longer worked for the licensee; they had resigned. ULP-F was hired on September 29, 2023, to provide direct cares and services. On April 17, 2024, the surveyor observed ULP-F administer oral medications to R1. From April 15, 2024, through April 17, 2024, on multiple occasions, the surveyor requested ULP-F's full employee record including the TB health history screen. The surveyor did not receive the TB health history screen prior to exiting the survey. ULP-F employee record included a chest x-ray completed February 3, 2023. ULP-F's employee record lacked a completed health history and symptom screening. On April 17, 2024, at 8:01 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated a majority of the staff could not have a TST due to previous positive Mantoux so the licensee required them to provide an x-ray or a QuantiFERON gold upon hire. CNS/RN-A stated employees completed a health history screen upon hire and then once per year. CNS/RN-A	{0 660}			

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{0 660}	Continued From page 31 stated they had not conducted an employee record audit because they recently changed their position with the licensee from the on-call registered nurse (RN) to the clinical nurse supervisor (CNS) less than 60 days ago. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer who had direct contact with the residents must have documentation of a baseline health symptom screening prior to providing care to residents. This included, at a minimum, the health symptom screening, tb skin testing via the Mantoux method. The CDC's document titled TB Screening and Testing of Health Care Personnel dated August 30, 2022, indicated all health care personnel should be screen for TB upon hire. TB screening is a process that included: - a baseline individual tb risk assessment; - a tb test; and - additional evaluation for TB disease as needed. No further information was provided.	{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 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	{0 680}			

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{0 680}	Continued From page 32 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post an EPP prominently. 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: The licensee's plan of correction dated January 30, 2024, included the following: - the facility had developed written documentation	{0 680}			

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{0 680}	Continued From page 33 that includes a disaster planning and EPP with all the required content in a binder for staff to reference; - the policy and procedure for disaster planning and EPP were reviewed and current; - exit diagrams were posted on each floor in the common areas of the facility; - EPP in-service was completed by all staff. - administrator would audit the EPP binder to ensure it was accurate and up to date once a month; and - administrator to update the EPP yearly. On April 16, 2024, at 11:53 a.m., the surveyor did not observe a readily accessible EPP available to staff, residents, and visitors. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K provided the surveyor, from the locked medication closet, 14 pages that included evacuation, fire, weather related and natural disasters, and communication plan policies. LALD/LPN-K stated this was what the licensee had at the facility for the EPP and a more in-depth EPP could be located online. The surveyor inquired how residents, visitors, or ULP would have access to the online EPP. LALD/LPN-K stated staff were trained on the EPP and residents participated in EPP drills. LALD/LPN-K stated, "we rely on the staff to direct the in case of an emergency." On April 16, 2024, at 12:17 p.m., via email, the surveyor received the licensee's EPP from agent (A)-C. The licensee's emergency disaster preparedness plan dated 2021 lacked evidence of the following required content: - annual review; - hazard and risk assessment; - strategies for addressing facility and community-based risk, including staffing	{0 680}			

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{0 680}	Continued From page 34 surges/shortages, and back-up plans; - quarterly review of missing resident policy; - subsistence needs for staff and patients specific to the facility; - accessibility to staff, residents and visitors; - emergency prep testing; and - roles under a waiver declared by secretary. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the items the licensee indicated they completed on the plan of correction were not completed. A-C stated as for implementation of the plan of correction "some were done, and others still have not been done." A-C stated, they created the correction plan and "immediate ones (orders) should have been corrected." The surveyor explained the immediate orders were corrected however, the other orders issued were not. A-C stated they would have to look into why certain parts of the plan of correction were not implemented to give the surveyor a conclusive answer. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated the licensee had multiple departments in the company and each department was responsible for their portion of the plan of correction. LALD/LPN-K stated the departments were in the process of "coming together" to make sure everything on the plan of correction made sense however, their meeting was cancelled last week, and they did not get to it. The licensees undated Emergency Management policy indicated the licensee "will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services". No further information provided.	{0 680}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: April 15, 2024, at 10:18 a.m., via email, the surveyor requested unlicensed personnel (ULP)-J's full employee record. On April 15, 2024, at 10:45 a.m., via email, the surveyor requested clinical nurse supervisor/registered nurse (CNS/RN)-A, ULP-B, ULP-E, and ULP-J's full employee records including EduCare (a training software program)	0 720			

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0 720	Continued From page 36 transcripts. In addition, the surveyor requested R1, R3, and R4's face sheet, signed service plan, signed assisted living contract, signed provider orders, medication administration record (MAR) for April, individual abuse prevention plan (IAPP), and medication administration plan. On April 15, 2024, at 11:10 a.m., agent (A)-C stated ULP-B and ULP-E had resigned from their positions at facility, and the licensee did not finish the corrections from the previous survey with their employee record prior to the end of their employment. In addition to verbal requests the surveyor continued to request for R1, R3, and R4's medical record on April 15, 2024, at 1:44 p.m., 2:55 p.m., April 16, 2024, at 7:26 a.m., and 9:48 a.m. The licensee was unable to provide R4's signed service plan, R1's signed provider orders and signed service plan, and R3's signed provider orders, signed contract, and signed service plan that were not completed during the survey. In addition to verbal requests the surveyor continued to request ULP-J's employee record via email on April 15, 2024, at 1:44 p.m., and 2:55 p.m. At 2:55 p.m., on April 15, 2024, the surveyor requested ULP-F's full employee record including any training and competencies. The surveyor continued to request ULP-J and ULP-F's employee records via email on April 16, 2024, at 7:26 a.m., 9:48 a.m., 11:41 a.m., and 2:22 p.m. The licensee was unable to provide all of ULP-F and ULP-J's training records and competency evaluations. On April 16, 2024, at 9:05 a.m., CNS/RN-A stated when they transitioned positions from the on-call registered nurse (RN) to the clinical nurse	0 720			

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0 720	Continued From page 37 supervisor (CNS) they noticed there were no prescribers' orders, so they faxed the pharmacy for the active orders and then faxed the active orders to the prescriber for signature. CNS/RN-A stated they were unable to locate those orders in the corporate office, and the orders were supposed to be uploaded into RTasks (a documenting software program). On April 16, 2024, at 1:40 p.m., A-C stated a previous house manager had the residents at the facility sign the new contract and a service plan however, they were unable to locate the document in the corporate office. The surveyor provided the licensee with a deadline of April 17, 2024, at 7:00 a.m., to provide all documents requested. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K asked for an extension from the surveyor's supervisor and stated they had medical and employee records in a secured storage that they were unable to access for up to 24 hours after they requested access. LALD/LPN-K stated the storage unit may contain some of the missing employee records. On April 16, 2024, at 1:57 p.m., the surveyor facilitated a phone conversation with the survey supervisor, LALD/LPN-K, who was in-person with the surveyor, and other staff members who were on LALD/LPN-K's phone. LALD/LPN-K stated they needed to provide a 24-hour notice to obtain access to the storage unit where some of their records were located, and stated they were concerned about the 7:00 a.m., deadline on April 17, 2024, provided to them by the surveyor. The survey supervisor inquired which documents the licensee believed to be in the storage unit from the list requested by the surveyor. LALD/LPN-K asked the other personnel on the phone, who's	0 720			

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0 720	Continued From page 38 response was not heard by the survey supervisor. LALD/LPN-K responded back to the survey supervisor they did not know what specific items from the request might be in the storage unit, but it could contain employee records such as trainings and competencies. The survey supervisor inquired why the licensee would have documentation for current staff located off-site in a storage unit. LALD/LPN-K declined to answer. The survey supervisor reminded LALD/LPN-K of the requirement to maintain documentation of actions taken to correct deficient practices, and to provide requested records in a timely manner. LALD/LPN-K stated there were multiple people in charge of different areas for the licensee, and they would do their best to provide information to the surveyor by the 7:00 a.m., deadline. The surveyor did not receive ULP-F and ULP-J's training records or competency evaluations prior to the end of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
{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.	{0 800}			

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{0 800}	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of 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 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). Findings include: On a facility tour on April 15, 2024, at 1:15 p.m., with agent (A)-C, the surveyor made the following observations of facility hazards and disrepair: There was a hole in the drywall wall finish material behind the front main exit/entry door. During a facility tour on April 15, 2024, at 1:30 p.m., A-C verified the above listed observations while accompanying on the tour. No further information was provided.	{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	{0 810}			

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{0 810}	Continued From page 40 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	{0 810}			

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{0 810}	Continued From page 41 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on April 15, 2024, at 1:45 p.m., agent (A)-C, stated the fire safety and evacuation plan was not located in a central location within the facility and was located at the corporate office in a different building. The fire safety and evacuation plan is required to be available at all times in the building in order for staff and residents to reference in the event of a fire or similar emergency. On April 16, 2024, at 12:20 p.m., agent (A)-C, provided documents on the fire safety and evacuation plan (FSEP). FIRE SAFETY AND EVACUATION PLAN The licensee FSEP sent by email and dated (revised) July 2021, failed to include the following: The number identification of resident sleeping rooms was not included on FSEP floor plan or on the door of resident sleeping rooms number 3 and number 4. The resident sleeping room numbers are required to be identified on the FSEP floor plan and the door of the rooms for occupants of the building to use for navigation and communication during a fire or similar emergency.	{0 810}			

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{0 810}	Continued From page 42 The FSEP did not identify specific fire protection actions for residents evident by not including in writing the specific procedure residents are required to perform in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include in writing and available, the unique and unusual needs (evacuation status) for each individual resident. During an interview on April 15, 2024, at 2:00 p.m., A-C, stated the facility FSEP would be sent to me via email to indicate updates made to the plan because the FSEP was not onsite for review by survey staff. No further information was provided.	{0 810}			
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	{0 900}			

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{0 900}	Continued From page 43 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of three residents (R3, 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). The findings include: The licensee's plan of correction dated January	{0 900}			

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{0 900}	Continued From page 44 30, 2024, included the following: - R4 signed a new contract with all the required contents included; - the licensee would establish a contract and ensure it was signed by each resident upon admission; - education was provided to administrative team to ensure contracts were signed upon admission; and - administrator would conduct an audit of the contracts following an admission. R3 R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract signed April 16, 2024, indicated R3 received assistance with bathing reminder, behavior management, dressing, grooming reminder, housekeeping, laundry, vital sign monitoring, and medication administration. On April 15, 2024, through April 17, 2024, on multiple occasions, the surveyor requested R3's signed contract that was completed prior to the survey from the licensee. The surveyor did not receive a contract for R3 signed prior to the survey. R4 R4 admitted to the licensee on October 15, 2023, and began receiving assisted living services. R4 previously discharged from the current licensee and transferred to a sister facility of the licensee (different Health Facility Identification Number (HFID)) and readmitted to the licensee on October 15, 2023.	{0 900}			

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{0 900}	Continued From page 45 R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of April 16, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's record included a document titled Resident Agreement signed August 1, 2021, provided to R4 by the licensee on a previous admission. R4's record lacked a current written contract with the required content provided by licensee upon re-admission. On April 16, 2024, at 10:11 a.m., the surveyor observed licensed assisted living director/licensed practical nurse (LALD/LPN)-K bring three new resident contracts into the facility for R1, R3, and R4. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated, "when I get back, we will have to have them sign the new contract." The surveyor asked if they had signed new contracts since the last survey. CNS/RN-A stated they had not signed another contract. The surveyor inquired why they had not received another contract since the plan of correction indicated the licensee had updated the contract. CNS/RN-A stated they didn't know and that would be a question for agent (A)-C. On April 16, 2024, at 1:40 p.m., A-C stated a previous house manager had all the residents at the facility sign a new contract with the licensee's updated contract after the previous survey. A-C stated they were unable to locate the documents in the corporate office.	{0 900}			

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{0 900}	Continued From page 46 The licensee's undated Assisted Living Contracts indicated the facility will establish a contract with each client [resident] at the time of admission. No further information provided.	{0 900}			
{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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of six employees (unlicensed personnel (ULP)-D, ULP-L). 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	{01290}			

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{01290}	Continued From page 47 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, included the following - employees that were not affiliated with the licensee on the previous survey on January 25, 2024, completed background studies; - newly hired staff would be required to complete a background study prior to providing services; - education was provided to administrator related to background studies, and the administrator would monitor; - review newly hired paper work to ensure a backgrounds study was completed. The plan lacked information related to affiliating the employee to the correct health facility identification number (HFID) and lacked a review of previous employee's background studies. On January 24, 2024, at 7:24 a.m., the surveyor requested the licensee's Minnesota Department of Human Services NETStudy 2.0 (web-based system used to submit background study requests) roster for HFID 35639. On April 16, 2024, at 9:21 a.m., the surveyor compared the licensee's Minnesota Department of Human Services NETStudy 2.0 roster for HFID 35639 to the licensee's employee list. The surveyor observed ULP-D and ULP-L were not listed on the roster. On April 16, 2024, at 9:47 a.m., the surveyor reviewed the NETStudy 2.0 roster for the entire company and observed the following employees affiliated to licensee's sister facilities:	{01290}			

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{01290}	Continued From page 48 - ULP-D affiliated to HFID 32874 and 98898; and - ULP-L affiliated to HFID 36870. On April 16, 2024, at 11:09 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated when a person applies for a position, the license sends the employee to be fingerprinted and fill out the form required to complete a background study. After the background study was cleared, the employee is eligible to start employment. LALD/LPN-K stated they affiliated employees to the HFID numbers they are employed at. The surveyor inquired why the ULP listed above were not affiliated. LALD/LPN-K stated, "well I really don't know. I sent instructions to the office to fix. We have a full-time office administrator she would be the one that does the backgrounds and affiliates staff." The licensee's undated Background Studies policy indicated each facility employee, volunteer or contractor who would provide direct care to residents must have a background study completed. No further information was provided.	{01290}			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370			

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NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
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01370	Continued From page 49 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 review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel ((ULP)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01370			

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01370	Continued From page 50 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J was hired on March 19, 2024, to provide direct cares and services. On April 16, 2024, at 7:56 a.m., the surveyor observed ULP-J administer oral medications to R3. ULP-J's record lacked the following: -training: - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing; respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. -competency: - standby assistance techniques and how to perform them.	01370			

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01370	Continued From page 51 On April 15, 2024, at 10:12 a.m., ULP-J stated they were trained on medication administration including as needed medication and narcotics, the facility's day to day tasks, getting residents up, housekeeping, making medical appointments, documenting in RTasks (a documenting software program) and all orientation required content. ULP-J stated they were not trained in transfers or ambulation because every resident who resided at the facility was independent. ULP-J was not sure if they received the training or competencies listed above. On April 16, 2024, at 11:27 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated staff completed training on the computer and then meet with a nurse to complete clinical orientation on regulations. LALD/LPN-K stated after clinical orientation staff would shadow a senior staff member and complete competency evaluations. The surveyor inquired what competency evaluations were completed. LALD/LPN-K stated medication, Hoyer lifts, and bathing. LALD/LPN-K stated, "some of the stuff required I don't have on top of my head, but I do know meds." On April 17, 2024, at 8:01 a.m., the surveyor inquired how the licensee completed training and competencies on the required 22 areas of 144G.61 Subdivision 2. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated the licensee completed an in-person training followed by a random supervision. CNS/RN-A stated after the supervision they completed a competency which included a return demonstration. CNS/RN-A stated they were unsure if all employees had received the required training and competencies as they did not review	01370			

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01370	Continued From page 52 employee's records since they began their new role with the licensee. The licensee's undated Qualifications, Training and Competency policy read, "Unlicensed personnel providing assisted living services must have: a. Successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in the statute b. Demonstrated competency by satisfactorily completing a written or oral test on the tasks of the unlicensed personnel will perform and on the topics listed in 144G.61, Subd. 2 c. Successfully demonstrated competency by a practical skills test." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=E	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;	01380			

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01380	Continued From page 53 (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-F, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: ULP-F ULP-F was hired on September 29, 2023, to provide direct cares and services. On April 17, 2024, the surveyor observed ULP-F administer oral medications to R1. ULP-F's record lacked the following training: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel.	01380			

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01380	Continued From page 54 On April 17, 2024, at 7:54 a.m., ULP-F stated they did not receive the training listed above. ULP-J stated they might have missed the training licensee was offered or it could be a training the licensee would offer soon. ULP-J ULP-J was hired on March 19, 2024, to provide direct cares and services. On April 16, 2024, at 7:56 a.m., the surveyor observed ULP-J administer oral medications to R3. ULP-J's record lacked the following: -training: - basic knowledge of body functioning and changes in body functioning, injuries, other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of a resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning. -competency: - reading and recording temperature, pulse, and respirations of the resident; - transfers techniques and ambulation; and - range of motioning and positioning. On April 15, 2024, at 10:12 a.m., ULP-J stated they were trained on medication administration including as needed medication and narcotics, the facility's day to day tasks, getting residents up, housekeeping, making medical appointments, documenting in RTasks (a documenting software	01380			

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01380	Continued From page 55 program) and all orientation required content. ULP-J stated they were not trained in transfers or ambulation because the residents at the facility were independent. ULP-J was not sure if they received the training or competencies listed above. On April 16, 2024, at 11:27 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated staff completed training on the computer and then meet with a nurse to complete clinical orientation on regulations. LALD/LPN-K stated after clinical orientation staff would shadow a senior staff member and complete competency evaluations. The surveyor inquired what competency evaluations were completed. LALD/LPN-K stated medication, Hoyer lifts, and bathing. LALD/LPN-K stated, "some of the stuff required I don't have on top of my head, but I do know meds." On April 17, 2024, at 8:01 a.m., the surveyor inquired how the licensee completed training and competencies on the required 22 areas of 144G.61 Subdivision 2. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated the licensee completed an in-person training followed by a random supervision. CNS/RN-A stated after the supervision they completed a competency which included a return demonstration. CNS/RN-A stated they were unsure if all employees had received the required training and competencies as they did not review employee's records since they began their new role with the licensee. The licensee's undated Qualifications, Training and Competency policy read, "Unlicensed personnel providing assisted living services must have:	01380			

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01380	Continued From page 56 a. Successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in the statute b. Demonstrated competency by satisfactorily completing a written or oral test on the tasks of the unlicensed personnel will perform and on the topics listed in 144G.61, Subd. 2 c. Successfully demonstrated competency by a practical skills test." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
{01470} SS=D	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,	{01470}			

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{01470}	Continued From page 57 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 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and	{01470}			

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{01470}	Continued From page 58 regulations before providing services for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - RN-A received orientation a guide to assisted living via EduCare (a training software); - New hired unlicensed personnel will complete a guide to assisted living via EduCare; - Education was provided to the administer to assign a guide of assisted living to all employees prior to floor orientation; and - Licensed assisted living director (LALD) will audit all newly hired record in EduCare to ensure content of orientation and all requirements and competencies have been completed prior to floor orientation. ULP-F was hired on September 29, 2023, to provide direct cares and services. On April 17, 2024, the surveyor observed ULP-F administer oral medications to R1. ULP-F's employee record included an overview of assisted living statues, home care bill of rights, review of types of assisted living services employee would provide and scope of services,	{01470}			

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{01470}	Continued From page 59 providers policies and procedures, principles of person-centered planning/service delivery, handling emergencies, reporting maltreatment, consumer advocacy services and handling complaints completed on October 23, 2023. ULP-F's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: - assisted living bill of rights. On April 17, 2024, at 8:01 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated employees received orientation to assisted living regulations on EduCare (a training software). CNS/RN-A was unaware of why ULP-F did not receive the assisted living bill of rights. CNS/RN-A stated they were aware of the requirement however, they had not conducted an audit on previous employee records. The licensee's undated Facility Employee Orientation policy, did not address the requirements of current licensure. No further information provided.	{01470}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	{01530}			

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{01530}	Continued From page 60 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-F, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	{01530}			

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{01530}	Continued From page 61 The findings include: The licensee's plan of correction dated January 30, 2024, indicated the following: - ULP-B, ULP-E and clinical nurse supervisor/registered nurse (RN)-A had completed dementia care training; - newly hired employees would complete dementia training prior to floor orientation; - education was provided to the licensed assisted living director (LALD) to ensure a minimum of eight hours of dementia care training was completed within 160 hours and two hours annually; - the administrator would monitor employee's dementia care compliance monthly for 12 months beginning in January and ending in December every year; and - the administrator to review EduCare (a training software program) competencies checklist to ensure all staff completed required training. On April 15, 2024, at 11:10 a.m., agent (A)-C stated ULP-B and ULP-E had resigned from their positions at facility, and the licensee did not finish the corrections with them prior to the end of their employment. ULP-F ULP-F was hired on September 29, 2023, to provide direct cares and services. On April 17, 2024, the surveyor observed ULP-F administer oral medications to R1. ULP-F's employee record transcript included five hours of initial training on dementia completed between October 19, 2023, and October 20, 2023. ULP-F's employee record lacked the required eight hours of dementia training to be	{01530}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/17/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
{01530}	Continued From page 62 completed with 160 hours of employment. On April 16, 2024, at 3:01 p.m., ULP-F stated they received between one hour and an hour and 30 minutes of dementia care training in person during a three-day orientation with the previous clinical nurse supervisor (CNS). On April 17, 2024, agent (A)-C stated ULP-F had worked 776.25 hours since start of employment. ULP-J ULP-J was hired on March 19, 2024, to provide direct cares and services. On April 15, 2024, at 11:30 a.m., the surveyor observed ULP-J administer oral medication to R1. ULP-J's employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. On April 15, 2024, at 10:12 a.m., ULP-J stated they were a full-time employee who worked 80 hours every two weeks and was hired in February 2024. ULP-J stated they started to work independently in the facility on March 18, 2024. ULP-J stated they did not receive any dementia care training however, they were going to attend a dementia care training on April 16, 2024, at 9:30 a.m. On April 17, 2024, at 8:04 a.m., via email correspondence, A-C indicated ULP-J worked 168 hours since start of employment. On April 16, 2024, at 11:27 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated in the past they were told	{01530}			

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{01530}	Continued From page 63 they did not need to complete dementia care training because the licensee did not serve dementia resident however, now they offered dementia care training. The surveyor inquired how many hours of dementia care training the licensee provided. LALD/LPN-K stated they used EduCare for core dementia training and scenarios for quarterly training however, they did not know the number of hours provided. In addition, LALD/LPN-K stated initial dementia care training needed to be completed within the first 30 or 90 days of hire. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the items the licensee indicated they completed on the plan of correction were not completed. A-C stated as for implementation of the plan of correction "some were done, and others still have not been done." A-C stated, they created the correction plan and "immediate ones (orders) should have been corrected." The surveyor explained the immediate orders were corrected however, the other orders issued were not. A-C stated they would have to look into why certain parts of the plan of correction were not implemented to give the surveyor a conclusive answer. Licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated the licensee had multiple departments in the company and each department was responsible for their portion of the plan of correction. LALD/LPN-K stated the departments were in the process of "coming together" to make sure everything on the plan of correction made sense however, their meeting was cancelled last week, and they did not get to it. On April 17, 2024, at 8:02 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated the licensee used EduCare to complete dementia	{01530}			

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{01530}	Continued From page 64 care training. CNS/RN-A stated direct care employees should receive eight hours of dementia care training. The surveyor inquired why ULP-F and ULP-J's employee records lacked eight hours of initial dementia care training. CNS/RN-A stated, "like I told you before the initial (survey) there was a lot of deficiency, and the director was let go. I am trying to get everything up to the requirements. I am aware and I am just starting to review employee files. Making sure they have the correct items assigned. I have been in this position less than 60 days. They didn't have a lot done when I took. It takes time when you walk into a mess, it takes time to clean it." The licensees undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the first 160 hours of employment. No further information was provided.	{01530}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	{01640}			

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{01640}	Continued From page 65 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for three of three residents (R1, R3, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - R1 and R4's service plans were executed and endorsed with a signature; - education was provided to nursing to complete service plans with a signature per statute; - the licensed assisted living director (LALD) would monitor and review client's [resident's]	{01640}			

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{01640}	Continued From page 66 admission paperwork to ensure completion of the service plan with required contents and file in the resident record. R1 R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's Service Plan (Wavier) - Addendum to Contract signed April 16, 2024, during the follow-up survey, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. On April 15, 2024, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-J administer oral medication to R1. R3 R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract signed April 16, 2024, during the follow-up survey, indicated R3 received assistance with bathing reminder, behavior management, dressing, grooming reminder, housekeeping, laundry, vital sign monitoring, and medication administration. On April 16, 2024, at 7:56 a.m., the surveyor observed ULP-J administer oral medication to R3. R4 R4 admitted to the licensee on October 17, 2023,	{01640}			

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{01640}	Continued From page 67 and began receiving assisted living services. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of April 16, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. On April 16, 2024, at 7:47 a.m., the surveyor observed ULP-J prepare and serve R4 breakfast. R1, R3, and R4's service plans lacked a signature or other authentication by the resident or resident's designated representative, prior to the initiation of the follow-up survey, indicating agreement on services to be provided. On April 16, 2024, at 10:11 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated they would have to print a new service plan for all residents in the facility to sign because there was not a service plan. The surveyor inquired if the service plan was lost or never signed. CNS/RN-A stated they did not know, they would go to the office, and when they returned, they would have the residents sign a new service plan. On April 16, 2024, at 1:40 p.m., the surveyor inquired why the service plan was not completed as indicated in the licensee's plan of correction. A-C stated a previous house manager had the residents at the facility sign the new service plan after the previous survey however, they were unable to locate the document in the corporate office.	{01640}			

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{01640}	Continued From page 68 The licensee's undated Service Plan policy indicated the service plan, and any revision of the service plan must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting the agreement on the services to be provided. No further information was provided.	{01640}			
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	{01730}			

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{01730}	Continued From page 69 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an accurate individualized medication management record for each resident to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally) The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - R4's medication management plan was completed; - individual medication management plans were	{01730}			

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{01730}	Continued From page 70 to be reassessed every 90-days and with change of conditions; - education was provided related to the medication management plan; and - "RN will monitor and review client's admission paperwork immediately to ensure completion of Individualized medication management plans and revisions with client was done. Results will be reviewed monthly in the QM meeting." R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3's diagnoses include Schizophrenia (delusions, false beliefs, hallucinations, unusual physical behavior, and disorganized thinking and speech), unspecified major depressive disorder, recurrent mild borderline personality disorder (may experience mood swings and emotional reactivity). R3's Service Plan (Waiver) - Addendum to Contract signed April 16, 2024, indicated R3 received assistance with bathing reminder, behavior management, dressing, grooming reminder, housekeeping, laundry, vital sign monitoring, and medication administration. On April 16, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-J administer oral medications to R3. R3's Individual Medication Management Plan dated February 4, 2024, included R3 took medications whole, medication was administered by facility staff, medications were kept locked in medication room, oral and topical medications ULP could be delegated, and methods for unlicensed staff to contact a nurse with questions	{01730}			

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{01730}	Continued From page 71 or concerns with medications. R3's medication management plan lacked an identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On April 16, 2024, clinical nurse supervisor/registered nurse (CNS/RN)-A stated they completed medication refills and ULP assisted with the medication refill process to ensure medications were available for the residents at the facility. CNS/RN-A stated they believed they had added who was going to be completing refills for R3. CNS/RN-A verified R3's medication management plan lacked the above information and stated they missed marking it off in RTasks (a documenting software program). The surveyor then observed CNS/RN-A update the medication management plan in RTasks. The licensee's undated Medication Management Services policy indicated based on the nursing assessment, the RN would develop and individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines and would develop specific procedures for medication management services that the staff would provide. No further information was provided.	{01730}			
{01820} SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	{01820}			

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{01820}	Continued From page 72 managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of two residents (R1, R3) who received medication administration by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, included the following: - R1 and R3 medication orders were obtained from their providers and placed in their medical record; - education was provided to the licensee on the procedure for obtaining order from prescriber and proper documentation on processing orders; and - an audit on all new orders was to be reviewed by the licensee weekly. R1 R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's diagnoses include borderline personality disorder, alcohol dependance uncomplicated,	{01820}			

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{01820}	Continued From page 73 opioid dependence, insomnia, major depressive disorder, alcohol abuse with withdrawal, diaphragmatic hernia with obstruction or gangrene, pain in left shoulder, alcohol hepatitis with ascites (inflammation of the liver, fluid in abdominal area), psychoactive substance dependance, attention deficit hyperactivity disorder (ADHD) predominantly inattentive type, idiopathic aseptic necrosis of left ankle (unknown origin of infection, tissue death), post-traumatic stress disorder (PTSD), other mixed anxiety disorders, stress fracture left ankle, and moderate persistent asthma uncomplicated. R1's Service Plan (Wavier) - Addendum to Contract signed April 16, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. On April 15, 2024, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-J administer oral medication to R1. R1's Med Amin Summary- Actual- Month dated April 1, 2024, through April 30, 2024, indicated R1 received belbuca 900 mcg (mcg) daily starting April 11, 2024, Methadose 2.5 milligrams (mg) twice daily until April 2, 2024, Methadose 5 mg twice per day April 3, 2024, through April 9, 2024, biotin 5000 micrograms (mcg) daily, Certavitamin one tablet daily, Zyrtec 10 mg daily, cholecalciferol 50 mcg daily, duloxetine delayed release 60 mg daily, ferrous sulfate 325 mg daily from April 1, 2024, through April 12, 2024, fluticasone propionate nasal suspension 50 mcg one spray into both nostrils daily, fluticasone-salmeterol aerosol powder breath	{01820}			

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{01820}	Continued From page 74 activated 100 mg -50 mg inhale one puff two times per day, gabapentin 1200 mg three times per day, hydrochlorothiazide 25 mg until April 11, 2024, Hydroxyzine 50 mg daily starting April 13, 2024, losartan potassium 50 mg daily, magnesium oxide 400 mg daily, omeprazole 40 mg daily until April 2, 2024, rabeprazole 20 mg daily, vitamin C 1000 mg daily, vitamin E external oil 2800 units (u) daily, amitriptyline 75 mg at bedtime, quetiapine 100 mg at bedtime, Xarelto 10 mg at bed time, acetaminophen 1000 mg as needed (PRN) every six hours, hydroxyzine 50 mg PRN three times per day, ondansetron 4 mg PRN three times a day, and senna 17.2 mg PRN two times as needed. On April 15, 2024, at 1:28 p.m., agent (A)-C provided the surveyor with a fax and stated it was R1's prescriber orders. The fax was sent to the licensee on April 15, 2024, from Geritom Medical Records department (R1's pharmacy) to A-C requesting the licensee obtain a signature from R1's medical provider for prescribed orders. The orders included the following medications: acetaminophen 1000 mg PRN every six hours, Sarna lotion 0.5 percent (%) PRN, bacitracin 500 units/gram (u/g) as need twice per day, ibuprofen 600 mg PRN daily, Narcan 4 mg as needed, ondansetron 4 mg three times per day, Ventolin inhaler 90 mcg, biotin 500 mcg daily, Certavite one tablet daily, cetirizine 10 mg daily, duloxetine 60 mg daily, ferrous sulfate 325 mg daily, fluticasone nasal spray 50 mcg daily, polyethylene glycol 17 grams (g) daily, hydrochlorothiazide 12.5 mg daily, losartan 50 mg daily, magnesium oxide 400 mg daily, vitamin C 1000 mg daily, vitamin D3 25 mcg daily, quetiapine 50 mg twice daily, Xarelto 10 mg daily, amitriptyline 75 mg daily, quetiapine 100 mg at bed time, Advair diskus 100 mcg/50 mcg daily,	{01820}			

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{01820}	Continued From page 75 belbuca 900 mcg twice per day, Eucerin intensive repair lotion twice a day, furosemide 20 mg once a day, rabeprazole 20 mg twice a day, senna 17.2 mg twice per day, gabapentin 1200 mg three times per day, hydroxyzine 100 mg three times per day. The document lacked a prescriber signature for the medications listed above. R3 R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3's diagnoses include Schizophrenia (delusions, false beliefs, hallucinations, unusual physical behavior, and disorganized thinking and speech), unspecified major depressive disorder, recurrent mild borderline personality disorder (may experience mood swings and emotional reactivity). R3 Service Plan (Waiver) - Addendum to Contract signed April 16, 2024, indicated R3 received assistance with bathing reminder, behavior management, dressing, grooming reminder, housekeeping, laundry, vital sign monitoring, and medication administration. On April 16, 2024, at 7:56 a.m., the surveyor observed ULP-J administer oral medications to R3. R3's Med Admin Summary -Actual- Month dated April 1, 2024, through April 30, 2024, indicated R3 received gabapentin 800 mg three times per day, lithium carbonate extended release (ER) 450 mg daily, Risperdal 2 mg twice per day, sertraline 200 mg daily, melatonin 3 mg daily, olanzapine 20 mg daily, prazosin 1 mg daily, trazadone 300 mg PRN at bedtime.	{01820}			

Minnesota Department of Health

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{01820}	Continued From page 76 On April 15, 2024, at 1:28 p.m., A-C provided the surveyor with a fax and stated they were R3's prescriber orders. The fax was sent to the licensee on April 15, 2024, from Geritom Medical Records department (R3's pharmacy) to A-C requesting the licensee obtain a signature from R3's medical providers for prescribed orders. The orders included the following medications: trazodone 300mg prn at bedtime, lithium carbonate 450 mg daily, sertraline 200 mg daily, melatonin 3 mg at daily, olanzapine 20 mg daily, prazosin 1 mg daily, risperidone 2 mg twice per day, gabapentin 800 mg three times per day. The document lacked a prescriber signature for the medications listed above. On April 16, 2024, at 9:05 a.m., the surveyor inquired why the prescriber orders provided to the surveyor lacked a prescriber's signature. Clinical nurse supervisor/registered nurse (CNS/RN)-A stated, "pharmacy did confirm the orders." CNS/RN-A stated they completed a monthly medication verification with the pharmacy. CNS/RN-A stated when they transitioned positions from the on-call registered nurse (RN) to the clinical nurse supervisor (CNS) they noticed there were no prescriber's orders, so they faxed pharmacy for the active orders and then faxed the active orders to the prescriber for signature. CNS/RN-A stated they were unable to locate those orders in the corporate office, and the orders were suppose to be uploaded into RTasks (a documenting software program). The licensee's updated Medication Prescriptions and Refills policy indicated a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff was responsible for	{01820}			

Minnesota Department of Health

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{01820}	Continued From page 77 setting up the medication, administering the medication, or providing other medication management services for a resident. No further information provided.	{01820}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with the original prescription drug label for one of two residents (R1). In addition, the licensee failed to discard expired medication for one of two residents that received medication dispensing services (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: The licensee's plan of correction dated January	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 78 30, 2024, included the following: - R1's prescription drugs have labels that were intact and legible; - expired or discontinued medication would be taken from medication bin and disposed of by immersing them in destroyer fluid; - staff were trained on reporting prescriptions with illegible labels and the policy related to removing or destroying discontinued or expired medication as soon as possible; and - an audit of the medication cabinet would be completed weekly to ensure discontinued and expired medication have been destroyed in a timely manner. R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's Service Plan (Wavier) - Addendum to Contract signed April 16, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. On April 15, 2024, at 9:42 a.m., the surveyor observed the medication closet and observed the following expired medications: - R1's three cards which contained one capsule, 29 capsules, and 30 capsules of omeprazole delayed release 60 mg with the expiration date of March 31, 2024. In addition, the surveyor observed the follow medications with illegible prescription labels: - R1's medication card lacked an intact medication prescription label from the pharmacy and contained three teal and orange oblong capsules.	{01890}			

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{01890}	Continued From page 79 On April 16, 2024, at 9:02 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated they checked the medication closet weekly for expired medication and destroyed the expired medication with the exception of narcotics. CNS/RN-A stated the narcotics would not be destroyed because they would need a second nurse to assist them, and the second nurse recently came back from vacation. CNS/RN-A stated they conducted an audit last week on the medication cabinet. The survey informed CNS/RN-A of the expiration date of the medications. CNS/RN-A stated the medication was discontinued and "I don't know how I missed that, but I do destroy meds." No further information provided.	{01890}			
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 resident's health or safety), and was issued at a	02290			

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02290	Continued From page 80 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 April 15, 2024, at 9:55 a.m., the surveyor observed an undated document titled Assisted Living General House rules located on the wall next to the dining room table. The document included the following house rules: - no illegal drugs or alcohol in or around the facility; - residents are expected to make up his/her own bed daily as well as clean up after themselves; - residents are expected to do his/her laundry weekly following the independent living laundry schedule unless stated in their contract; - resident are expected to follow weekly chore list posted in the kitchen; - residents are expected to maintain proper hygiene; - all dishes must be washed after use; - eating is allowed only in the kitchen and dining room; - visiting hours are from 10:00 a.m. to 8:00 p.m.; - the licensee requires all resident to fill out the behavioral health emergency response plan form; and - prior to moving belongings into their shared space, all new residents are required to wash all clothing. The surveyor did not observe a chore list posted in the kitchen. On April 15, 2024, at 1:30 p.m., R3 stated the house rules was posted "somewhere on the board" of information.	02290			

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02290	Continued From page 81 On April 16, 2024, at 7:56 a.m., unlicensed personnel (ULP)-J stated they enforced the house rules posted on the wall. The surveyor inquired if the residents completed chores within the facility. ULP-J stated residents were to keep their bedrooms tidy and their beds made daily however, if they did not then staff would assist with cleaning if needed. In addition, ULP-J stated dishes were not to be left in the sink however, if a resident did not clean dishes they would assist. ULP-J stated residents were not allowed to have alcohol within the facility and if they noticed a presence of alcohol, they would contact management to follow up with the situation. ULP-J stated the licensee restricted visiting hours and no visitors were allowed before breakfast, and if the residents did not follow visiting hours, they would contact management. On April 16, 2024, at 9:05 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated there was no alcohol allowed in the facility and if a resident was seen with alcohol the resident would get a written warning followed by a termination warning, and "This is a drug-free and alcohol-free home." CNS/RN-A stated residents were encouraged, not expected, to complete the daily tasks listed above to maintain independence. CNS/RN-A stated they discouraged people from coming out of visiting hours for safety reasons. CNS/RN-A stated the licensee was not implementing anything on the paper and they did not know why it was posted. CNS/RN-A stated, "half of the things go against residents right on there." On April 16, 2024, at 10:47 a.m., R1 stated the licensee did not allow alcohol on the premises however, they liked having that rule due to a previous addiction. R1 stated they did not know if	02290			

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02290	Continued From page 82 the licensee restricted visitors because they had infrequent visitors. R1 stated they asked ULP-F to clean the toilet because it was dirty for days. R1 stated, "I could have cleaned it, but I didn't want to. [ULP-F] freaked out that is not our job this is a independent house." On April 16, 2024, at 11:15 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated the licensee had house rules however, they believed the posting was removed from the wall and did not know how it was reposted. LALD/LPN-K stated no alcohol was allowed in the facility and if residents were seen with alcohol they would redirect, complete a care conference with the case manager, and give a warning or a notice. LALD/LPN-K stated the residents were not expected to complete daily tasks, however, were encouraged to do as much as they could to promote independence. LALD/LPN-K stated they reviewed house rules with residents upon admission and give the residents a copy of it. LALD/LPN-K stated the licensee should have used different wording on the house rules as they encourage residents and do not demand them to follow the rules. On April 16, 2024, at 2:39 p.m., R3 stated they signed house rules upon admission. R3 stated the licensee restricted visitors after 8:00 p.m., and did not allow alcohol on the premises. R3 stated if they used the kitchen independently, they were expected to clean up after themselves. The licensee's undated Assisted Living Bill of Rights indicated the licensee's staff may not request nor obtain from the resident any waiver of any of their rights. No further information was provided.	02290			

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02290	Continued From page 83	02290			
{03090} SS=C	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's plan of correction dated January 30, 2024, indicated continuous electronic monitoring device notice had been posted at the	{03090}			

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{03090}	Continued From page 84 entrance of the facility. On April 15, 2024, at 9:23 a.m., upon entering the assisted living facility (ALF), the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On April 16, 2024, at 8:40 a.m., clinical nurse supervisor/registered nurse (CNS/RN)-A stated verified there was no electronic monitoring notice posted and stated, "there is no one here who has it, so we decided not to post it." On April 16, 2024, at 11:15 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-K stated they did not know why there was not an electronic monitoring notice posted. On April 16, at 1:35 p.m., agent (A)-C stated they generated the document however, they would have to look into why it was never posted at the facility. The licensee's undated Electronic Monitoring policy with an effective date January 1, 2020, indicated the facility complies with the Minnesota Electronic Monitoring law. No further information provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2024

Licensee

Angel's Health and Home Care Services Inc
4213 63rd Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35639015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 25, 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 suvey:

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

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

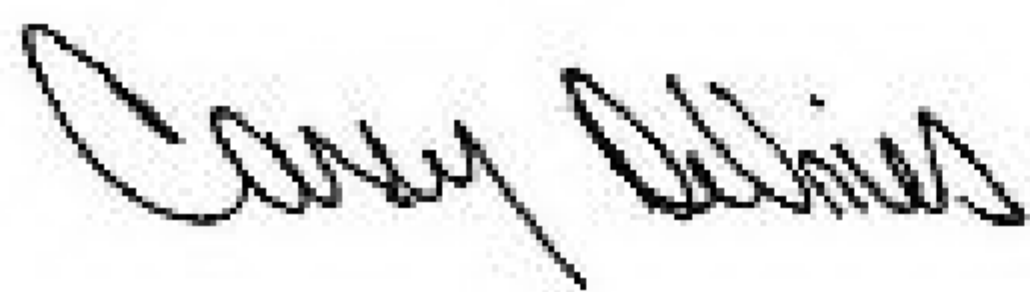
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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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: SL35636015-0 On January 22, 2024, through January 25, 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 three residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on January 23, 2024, issued for SL35639015-0, tag identification 0820. On January 25, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on January 23, 2024, issued for SL35639015-0, tag identification 0830.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/25/2024
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0 000	Continued From page 1	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	0 250			

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

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0 250	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 22, 2024, at 10:02 a.m., agent (A)-C 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	0 250			

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

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0 250	Continued From page 5 and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by A-C on July 3, 2023. The licensee had an assisted living license issued on August 1, 2023, with an expiration date of July 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for medications, treatments, or	0 250			

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0 250	Continued From page 6 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; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On January 25, 2024, at 12:23 p.m., A-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0460, 0470, 0480, 0485, 0490, 0510, 0630, 0650, 0660, 0680, 0780, 0800, 0810, 0820, 0830, 0900, 1290, 1470, 1500, 1530, 1640, 1730, 1760, 1820, 1890, 1910, 1940, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time;	0 460			

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0 460	Continued From page 7 (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2023, at 10:11 a.m., agent (A)-C stated the licensee offered a means for the resident to request assistance for health and safety upon admission. A-C stated if resident declined a call assistance device, the licensee would document the refusal in the "corporate record". A-C stated if residents accepted the call	0 460			

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0 460	Continued From page 8 assistance device, it would be documented in the resident's care plan. A-C stated all residents were ambulatory, verbal, and had personal phones they could use to contact employees. A-C stated all current residents declined a device to request assistance. The surveyor requested to see documentation of the residents being offered a call assistance device. On January 22, 2024, at 11:23 a.m., during a facility tour, the surveyor observed a two-level home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas which would function as a call assistance device. On January 25, 2024, at 10:26 a.m., R3 stated there were not offered a call assistance device upon admission to the facility. In addition, R3 stated if they needed assistance they would "yell". On January 25, 2024, at 11:05 a.m., registered nurse (RN)-A stated they informed management for the need of a call assistance device however, management's response was the residents at the facility were mobile and had personal phones they could contact employees with. The surveyor inquired if R1 and R3 were offered call assistance devices. RN-A stated, "they were offered and declined is what I was told." The surveyor inquired if the licensee had documentation of call assistance devices being offered to residents. RN-A stated they were unable to locate the documentation to show the R1 and R3 were offered and/or refused the use of a call assistance device. On January 25, 2024, at 12:26 p.m., R1 stated they were not offered a call assistance device upon admission to the facility. In addition, R1	0 460			

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0 460	Continued From page 9 stated if they needed assistance they would "yell" if they had a problem or use their personal cell phone to call one of the six employee numbers they had prograded into their phone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470			

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0 470	Continued From page 10 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. The licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. 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: The licensee held an assisted living license. The facility was licensed for a capacity of four residents. On January 22, 2024, at 10:02 a.m., during the entrance conference, agent (A)-C stated the staffing plan was created by the office administrator, reviewed by A-C, then sent to the assisted living director and the clinical nurse supervisor (CNS) to be published. The surveyor requested to see the licensee's written staffing plan.	0 470			

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0 470	Continued From page 11 STAFFING PLAN In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42 a.m., and January 25, 2024, at 11:13 a.m., requesting to see the licensee's staffing plan. On January 25, 2024, at 11:13 a.m., registered nurse (RN)-A stated they did not know how the licensee created their staffing plan and requested the surveyor wait until the CNS returned from leave to ask. On January 25, 2024, at 11:56 a.m., A-C stated they had a staffing plan "somewhere". On January 25, 2024, at approximately 12:26 p.m., A-C provided the surveyor with a document titled (name of licensee) dated January 24, 2024, and indicated it was the licensee's staffing plan. The document included position titles, employee names, employees' days of work and hours, and included a signature from A-C. The document was completed during the survey. The staffing plan lacked evidence the licensee considered the following items; -an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; -ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24- hour per day basis and; -ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.	0 470			

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0 470	Continued From page 12 POSTING On January 22, 2024, at 9:54 a.m., the surveyor observed an undated document titled (name of licensee) 63rd House Weekly Schedule posted on the common area bulletin board. The document included 14 weeks (Sunday through Saturday) of undated unlicensed personal scheduled shifts with the same schedule repeated week to week. On January 22, 2024, at 10:02 a.m., A-C stated changes in the staff schedule were communicated via text message and was supposed to be posted on the common area bullet board. A-C stated it may be down stairs in the office (locked office). A-C verified the current posting was incorrect. On January 25, 2024, at 11:13 a.m., registered nurse (RN)-A stated the licensee staffing schedule was posted on WhatsApp (a communication application) and to their knowledge they have not seen a schedule posted at the facility. RN-A stated, "I have brought it up with management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480			

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0 480	Continued From page 13 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 January 22, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 485			

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0 485	Continued From page 14 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 24, 2024, at 7:12 a.m., agent (A)-C provided the surveyor with a blank contract titled Resident Contract for Assisted Living and stated it was used for all residents. The licensee's Assisted Living Contract pages 12 and 13 included: "This Assisted Living Facility offers all of the	0 485			

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0 485	Continued From page 15 following (included in the Month Base Fee): - At least three meals daily with snacks available seven (7) days per week." The licensee's Resident Contract for Assisted Living lacked the option to opt out of the meal plan. On January 25, 2024, at 12:36 p.m., A-C stated residents can choose a meal but do not have to pay for it. A-C stated, "is in error it should not be there, they do not always go through the attachments." The licensee's undated Assisted Living Contracts policy indicated the assisted living facility (ALF) require that three meals and snacks be made available and state the facility cannot require a resident to include and pay for means in their contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the	0 490			

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0 490	Continued From page 16 community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents who received 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, through January 25, 2024, the surveyor did not observe any activities planned or offered to the residents. Residents remained in their rooms, in common living area, outside, or in the kitchen.	0 490			

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0 490	Continued From page 17 On January 22, 2024, at 10:02 a.m., during the entrance conference, agent (A)-C stated the licensee provided a daily program of social and recreational activity. On January 22, 2024, at 11:24 a.m., during facility tour, the surveyor did not observe a daily activity schedule posted in the facility. On January 25, 2024, at 10:11 a.m., unlicensed personnel (ULP)-E stated they took residents out of the facility for activities in the summer however, in the winter there were not many actives to do. ULP-E stated activities were scheduled based on resident requests. The surveyor inquired if the licensee performed activities within the facility. ULP-E stated they "just do the outdoor activities." On January 25, 2024, at 10:18 a.m., R3 stated they moved into the facility six months ago and had not been offered activities. R3 stated, "Manager did ask last week, we need to figure out activities." R3 stated they were "bored." The surveyor observed R3 frequently pacing in the common areas throughout the survey. On January 25, 2024, at 11:05 a.m., registered nurse (RN)-A stated to their knowledge activities were offered however, did not know what activities were offered. RN-A stated, "I have no idea what they consist of. When I was hired, there was activities." On January 25th, 2024, at 12:26 p.m., R1 stated the licensee did not offer daily activities for the residents and they would not participate if offered. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 490			

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0 490	Continued From page 18 (21) days	0 490			
0 510 SS=D	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 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for one of two unlicensed personnel ((ULP)-E). 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:	0 510			

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0 510	Continued From page 19 On January 23, 2024, at 7:58 a.m., the surveyor observed ULP-E wearing gloves for medication administration to R3. After the medication administration, ULP-E used an electronic tablet to document the medication administration, removed gloves, and placed gloves into the trash can. Without performing hand hygiene, ULP-E walked to R1's room, knocked on the door, asked R1 to ask if previous medication administration was effective, returned to the dining table, and used the electronic tablet. The surveyor did not observe ULP-E immediately perform hand hygiene after glove removal. On January 23, 2024, at 8:05 a.m., the surveyor inquired about infection control practices, specifically related to hand hygiene. ULP-E stated hands should be washed with soap between fingers before gloves were put on. The surveyor inquired why hand hygiene was not performed after glove removal. ULP-E stated they did not realize hand hygiene was not completed after glove removal. On January 23, 2024, at 12:25 p.m., the registered nurse (RN)-A stated staff were trained to perform hand hygiene after resident care and after bathroom use. RN-A stated staff were trained to change gloves between residents and to use hand sanitizer or hand wash after glove removal. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated after glove removal, hand hygiene should be performed. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated the licensee would be consistent with current guidelines from the Center	0 510			

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0 510	Continued From page 20 for Disease Control and Prevention (CDC). The CDC document titled Hand Hygiene Guidance dated January 20, 2020, recommends a healthcare personnel performed hand hygiene immediately after glove removal and after touching a patient or patient's immediate environment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R3, R4). This practice resulted in a level two violation (a	0 630			

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0 630	Continued From page 21 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's diagnoses include borderline personality disorder, alcohol dependance uncomplicated, opioid dependence, insomnia, major depressive disorder, alcohol abuse with withdrawal, diaphragmatic hernia with obstruction or gangrene, pain in left shoulder, alcohol hepatitis with ascites (inflammation of the liver, fluid in abdominal area), psychoactive substance dependance, attention deficit hyperactivity disorder (ADHD) predominantly inattentive type, idiopathic aseptic necrosis of left ankle (unknown origin of infection, tissue death), post-traumatic stress disorder (PTSD), other mixed anxiety disorders, stress fracture left ankle, and moderate persistent asthma uncomplicated. R1's unsigned service plan titled Service Plan (Wavier) - Addendum to Contract effective date January 4, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. R1's IAPP dated January 4, 2024, indicated R1 was at risk to be abused by others, however, did not include the following required content: - the person's risk of abusing other vulnerable	0 630			

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0 630	Continued From page 22 adults. R3 R3's diagnoses include Schizophrenia (delusions, false beliefs, hallucinations, unusual physical behavior, and disorganized thinking and speech), unspecified major depressive disorder, recurrent mild borderline personality disorder (may experience mood swings and emotional reactivity). R3's signed Service Plan (Waiver) - Addendum to Contract effective date January 11, 2024, indicated R3 received assistance with bathing reminders, behavior management, dressing assistance, grooming reminder, housekeeping, laundry, medication administration, and vital signs (VS). R3's IAPP dated November 17, 2023, indicated R3 was at risk to be abused by others and specific statements, however, did not include the following required content: - the person's risk of abusing other vulnerable adults. R4 R4 diagnoses include diabetes mellitus type 2, chronic kidney disease stage 3 (kidney failure), chronic pain (ongoing pain), osteoarthritis of the right knee (tissues breakdown in the joint), depression with anxiety, degenerative disc disease, and hypertension. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of January 23, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive	0 630			

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0 630	Continued From page 23 airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's IAPP dated January 25, 2024, indicated R4 was at risk to abuse other vulnerable adults, however, did not include the following required content: - the person's risk of being abused by other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 25, 2024, at 11:18 a.m., registered nurse (RN)-A stated the IAPPs should be individualized to the resident. RN-A stated the IAPPs are handled by the director. The licensee's undated Abuse Prevention Plan policy read "All residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650			

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0 650	Continued From page 24 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-E). 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).	0 650			

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0 650	Continued From page 25 The findings include: On January 22, 2024, at 10:02 a.m., during the entrance conference, agent (A)-C stated they were aware of the requirements for contents of the employee record, and employee records were stored in paper format at the cooperate office. A-C stated the office recently had a fire however, no documents were destroyed. RN-A RN-A was hired on December 12, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. RN-A's employee record did not include any hours of dementia training and lacked the initial eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. On January 25, 2024, at 11:19 a.m., RN-A stated they transferred their initial dementia care education from a previous employment. RN-A stated, "I thought so long as it is done you can transfer all the education." ULP-B ULP-B was hired on June 14, 2022, to provide direct services to residents. On January 22, 2024, at 1:20 p.m., the surveyor observed ULP-B administer medication to R1. ULP-B's employee record lacked the following required content: - training which include the following: - documentation requirements for all services provided;	0 650			

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0 650	Continued From page 26 - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preference, cultural background, and family; - observation, reporting and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel; - recognizing physical emotional, cognitive, and developmental needs of the resident; - standby assistance techniques and how to perform them; and - range of motioning and positioning. - safe transfer techniques and ambulation; - competency evaluations which include the following: - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motion and positioning; and - setting up medications for an unplanned time away from home. On January 25, 2024, at 10:19 a.m., the surveyor attempted to inquire about ULP-Bs trainings and competencies. ULP-B stated, "Yes competency for meds by a nurse, we do with a nurse. These are professional people, the rest you can do with the company. I am going home; I need to sleep." ULP-B then exited the facility.	0 650			

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0 650	Continued From page 27 ULP-E ULP-E was hired on September 20, 2022, to provide direct services to residents. On January 23, 2024, at 7:05 a.m., the surveyor observed ULP-E administer medication to R1. ULP-E's employee record lacked the following required content: - training which include the following: -documentation requirements for all services provided; -standby assistance techniques and how to perform them; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preference, cultural background, and family; -observation, reporting and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel; -recognizing physical emotional, cognitive, and developmental needs of the resident; -range of motioning and positioning; and -safe transfer techniques and ambulation. - competency evaluations which include the following: - appropriate and safe techniques in personal hygiene and grooming including hair and bathing, care of teeth, gums, and oral prosthetic devices, care of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation;	0 650			

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0 650	Continued From page 28 - range of motion and positioning; and - setting up medications for an unplanned time away from home. On January 24, 2024, at 9:44 a.m., ULP-E stated they received training which included competency evaluations during a three day in-person orientation. ULP-E stated the licensee completed training sessions throughout the year and provided additional education as needed based on resident's needs. In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42 a.m., and January 25, 2024, at 11:13 a.m., requesting to see full employee records for RN-A, ULP-B and ULP-E. On January 25, 2024, at 9:50 a.m., A-C stated they were unable to locate further employee records for RN-A, ULP-B, and ULP-E. On January 25, 2024, at 11:24 a.m., RN-A stated the licensee completed training via EduCare (a training software program) and in-person meetings. RN-A stated competencies were completed by the clinical nurse supervisor (CNS), and they assisted with re-education as needed. The licensee's undated Employee Records policy read, "1. Employee records must include the following information: a. Evidence of current professional licensure, registration, or certification if licensure, registration or certification is required b. Records of orientation, required annual training, infection control training and competency evaluations	0 650			

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0 650	Continued From page 29 c. Current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision d. Documentation of annual performance reviews that identify areas of improvement needed and training needs e. For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those screenings; and f. Documentation of the background study as required under section 144.057." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=E	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.	0 660			

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0 660	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-B, ULP-E). 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). The findings include: The facility TB risk assessment form dated July 1, 2023, indicated the facility was at a low risk for TB transmission. In addition, agent (A)-C was responsible for maintaining the TB screening records. On January 22, 2024, at 10:02 a.m., during the entrance conference, agent (A)-C stated employees completed a two-page questionnaire related to TB upon hire to help the licensee assess the risk of TB. A-C stated they had a contract with an outside agency that conducted the TB testing for the employees or the	0 660			

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0 660	Continued From page 31 employees had the option to go to their primary care clinic. In addition, A-C stated the employee needed to show proof of TB results prior to working with residents. A-C stated they were aware of the requirements for contents of the employee record and employee records were stored in paper format in the cooperate office. A-C stated the office recently had a fire however, no documents were destroyed. ULP-B ULP-B was hired on June 14, 2022, to provide direct services to residents. ULP-B's employee record included a Baseline TB Screening Tool for Healthcare Workers (HCWs) signed by ULP-B on June 3, 2022. The document included two sections, one section assessed current TB symptoms, and one section for testing for the presence of TB. The two sections were not filled in by the licensee or ULP-B. On January 25, 2024, at 10:19 a.m., ULP-B stated they completed a TB blood test prior to hire and were going to receive another TB blood test in three months. ULP-E ULP-E was hired on September 20, 2022, to provide direct services to residents. ULP-E's employee record included an undated Baseline TB Screening Tool for Healthcare Workers (HCWs). The document included three sections, one section assessed for current symptoms of TB, one section assessed the HCW history, and one section tested for the presence of TB infection. The three sections were not filled in by the licensee or ULP-E.	0 660			

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0 660	Continued From page 32 On January 25, 2024, at 10:03 a.m., ULP-E stated they completed a chest Xray at a hospital in Fargo prior to working at the facility. ULP-E stated, "I told them to go to my chart and they could get the information." On January 25, 2024, at 11:36 a.m., registered nurse (RN)-A stated TB screening should be completed upon hire. RN-A stated the clinical nurse supervisor (CNS) may have the ULP-B and ULP-E employee records located in a folder they do not know about because they were "old school." In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42 a.m., and January 25, 2024, at 11:13 a.m., requesting to see full employee records for RN-A, ULP-B, and ULP-E. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer who had direct contact with the residents must have documentation of a baseline health symptom screening prior to providing care to residents. The CDC's document titled TB Screening and Testing of Health Care Personnel dated May 16, 2019, indicated a baseline individual TB risk assessment should be completed upon. In addition, the document indicated a TST was used to test health care personnel for TB upon hire, and two-step testing should be used. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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

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0 680	Continued From page 34 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at 11:17 a.m., the surveyor did not observe a readily accessible EPP available to staff, residents, and visitors. On January 24, 2024, at 9:48 a.m., agent (A)-C stated the EPP was accessible in Rtask (computer software) and a hard copy was kept at the off-site corporate office. On January 24, 2024, at 11:05 a.m., the surveyor inquired with unlicensed personnel (ULP)-F how staff accessed the EPP. ULP-F stated, "there is no binder here I can show you. We were given a binder to take home." On January 25, 2024, at 11:28 a.m., registered nurse (RN)-A stated they were unsure where the EPP was kept for the facility. RN-A stated it was updated quarterly unless there were changes in resident conditions. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - hazard and risk assessment; - strategies for addressing facility and community-based risk, including evacuation plans, staffing; surges/shortages, and back-up plans;	0 680			

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0 680	Continued From page 35 - quarterly review of missing resident policy; - subsistence needs for staff and patients specific to the facility; - accessibility to staff, residents and visitors; - primary evacuation location; and - roles under a waiver declared by secretary. On January 24, 2024, at 12:54 p.m., A-C stated the EPP was updated at least yearly or if a resident's condition changed. A-C stated each resident was assessed for their vulnerability to emergencies which included a risk level. A-C stated the EPP they found they did not see the full evaluation which was an area they would fix. The licensees undated Emergency Management policy indicated the licensee "will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each	0 780			

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0 780	Continued From page 36 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 interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 25, 2024, at 11:10 a.m., with agent (A)-C, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility.	0 780			

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0 780	Continued From page 37 During the tour A-C activated the test button of the smoke alarm in the main floor hallway and the alarm sounded in that location but was not interconnected to all other alarms in the facility. On January 25, 2024, at 1:23 p.m., A-C sent a video of another test of the interconnection of the alarms via email stating they were interconnected as required. Survey staff was not able to verify interconnection of all smoke alarms after viewing the video. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During an interview on January 25, 2024, at 11:25 a.m., A-C, stated he would send a video of the smoke alarm interconnection. Survey staff was not able to verify the interconnected smoke alarm operation by viewing the video. TIME PERIOD FOR CORRECTION: One (1) day.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800			

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0 800	Continued From page 38 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 25, 2024, at 11:00 a.m., with agent (A)-C, the surveyor made the following observations of facility hazards and disrepair: There was a hole in the drywall wall finish material behind the front main exit/entry door. The carpet was missing causing the stair rise from one step to the next to be a different height on the bottom three steps leading into the basement. Floor covering on stairway steps is required to be maintained in order to keep all step equal in height. During a facility tour on January 25, 2024, at 11:20 a.m., A-C verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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

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0 810	Continued From page 40 review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on January 25, 2024, at 11:20 a.m., agent (A)-C, stated the fire safety and evacuation plan was not located in a central location within the facility and was located at the corporate office. On January 25, 2024, at 11:20 a.m., agent (A)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated January 1, 2023, failed to include the following: The number identification of resident sleeping rooms was not included on FSEP floor plan or on the door of resident sleeping rooms number 3 and number 4. The resident sleeping room numbers are required to be identified on the FSEP floor plan and the door of the rooms for	0 810			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 41 occupants of the building to use for navigation and communication during a fire or similar emergency. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include procedures employees are required perform specific to the facility in the event of a fire or similar emergency. The plan inappropriately included information including, the doors automatically closing when the fire alarm system is activated, and the fire department will be automatically notified. During an interview on January 25, 2024, at 11:25 a.m., A-C stated the facility does not have a fire alarms system, automatic closing doors and automatic notification of the fire department. The FSEP did not identify specific fire protection actions for residents evident by not including in writing the specific procedure residents are required to perform in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include in writing and available, the unique and unusual needs (evacuation status) for each resident. During an interview on January 25, 2024, at 11:30 a.m., AS-C, stated the facility FSEP did not include resident room numbers on floor plan,	0 810			

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0 810	Continued From page 42 employee procedures required during a fire or similar emergency in writing, resident procedures required during a fire or similar emergency in writing, accurate information related to emergency alarms and other emergency systems, and unique and unusual needs of each resident for evacuation in the event of a fire or similar emergency. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the residents were offered training of the FSEP procedures. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing written documentation training was provided to employees based on the FSEP procedures. During an interview on January 25, 2024, at 11:35 a.m., A-C stated training was not documented as required for residents and the drills performed were considered part of the training for employees but not documented that way. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation the drills were completed in the required sequence. Documentation was provided for drills completed June 8, 2023, and October 15, 2023.	0 810			

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0 810	Continued From page 43 During an interview on January 25, 2024, at 11:40 a.m., A-C, stated 4 drills were completed in 2023 but not documented and the sequence of drills completed did not meet the required sequence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents 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	0 820	his immediate correction order identified on January 23, 2024, has had the immediacy lifted as of December 14, 2023, however non-compliance remained a scope and level of I.		

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0 820	Continued From page 44 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 23, 2024, at 8:32 a.m. with agent (A)-C and unlicensed personnel (ULP)-E, it was observed that emergency escape and rescue openings were not provided in resident room number 1 occupied by R1, unoccupied resident room number 2, and occupied resident room number 3 occupied by R3. OCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room number 1 occupied by R1, emergency escape and rescue clear window opening measurements are 27 ½ inches wide, 16 1/4 inches in height and 447 square inches in openable area. Resident sleeping room number 3 occupied by R3, emergency escape and rescue clear window opening measurements are 40 1/2 inches wide, 14 inches in height and 567 square inches in openable area. The windows were measured with A-C, and ULP-E, and survey staff present. The window in resident sleeping room number 1 did not meet the minimum requirements for opening height and total square inch area. The window in resident sleeping room number 3 did not meet the minimum requirements for opening height. UNOCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room number 2 emergency escape and rescue clear window opening measurements are 27 1/2 inches wide, 15 1/2	0 820			

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0 820	Continued From page 45 inches in height and 426 square inches in openable area. The window was measured with A-C and ULP-E, and survey staff present. The window did not meet the minimum requirements for clear opening height and for total openable area. During a phone interview on January 23, 2024, at 9:45 a.m. with A-C, it was explained that at least one emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and a maximum sill height from the floor of 48 inches. During a phone interview on January 23, 2024, at 9:45 a.m., A-C stated the windows did not meet the minimum clear opening requirements and a contractor will be hired to replace the existing windows. TIME PERIOD FOR CORRECTION: immediate	0 820			
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable	0 830	On January 24, 2023, the immediacy of correction order 0830 was removed,		

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0 830	Continued From page 46 state and local laws, regulations, standards, ordinances, and codes related to smoking for one of three residents (R4). 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 the potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at 9:33 a.m., the surveyor entered the assisted living facility (ALF) and noted an odor of cigarette smoke and a no smoking including e-cigarettes sign on the licensee's front door. On January 22, 2024, at 9:43 a.m., during a facility tour, the surveyor observed a two-level home. The main level was comprised of a living room, kitchen, two occupied bedrooms, one unoccupied bedroom, and one shared bathroom. The basement was comprised of a common living space, one occupied bedroom room, one shared bathroom, one office, and a laundry area. The surveyor noted a stronger odor of cigarette smoke in the basement, near R4's room. The surveyor entered R4's room and did not observe any evidence of smoke, however, the window was opened. On January 23, 2024, at 9:50 a.m., unlicensed personnel (ULP)-E stated residents were allowed to smoke outside and there was a designated smoking area outside the front door. ULP-E	0 830	however non-complianc remained, and the scope and level remained unchanged.		

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0 830	Continued From page 47 stated residents do not smoke in their rooms and were not aware of anyone smoking in the house. In addition, ULP-E stated they were trained to tell residents not to smoke in their rooms and to update the registered nurse (RN) and administrator if residents were found smoking indoors. R4 was admitted to the licensee on October 15, 2023, and began receiving assisted living services. R4 diagnoses include diabetes mellitus type 2, chronic kidney disease stage 3 (kidney failure), chronic pain, osteoarthritis of the right knee, depression with anxiety, degenerative disc disease, and hypertension. R4s unsigned Service Plan (Waiver) Addendum to Contract effective date January 23, 2024, indicated R4 received assistance with appointments, bathing assistance, behavior management, housekeeping, socialization, continuous positive airway pressure (CPAP) therapy, dressing, grooming, meal assistance, medication reminder, transportation, transfer assistance, and ambulate assistance. On January 23, 2024, at 10:47 a.m., the surveyor observed a circular metal candle lid turned upside down, covered with grey ash material under the television in R4's bedroom. On January 23, 2024, at 10:51 a.m., the surveyor inquired about the circular metal candle lid under the television that contained a grey ash material. R4 stated the grey ash material was ashes from a cigarette. R4 stated they opened their room window, and they smoked by the window in their room. R4 stated they placed the cigarette end	0 830			

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0 830	Continued From page 48 into the basement toilet when they finished smoking. On January 23, 2024, at 11:09 a.m., the surveyor inquired about smoking inside of the ALF. R1 stated, "we are not supposed to, but the guy downstairs does all the time. I use a book to cover my room vent to stop the smell." R1 stated they had also observed R4 smoking in the kitchen and common area when staff were present. R1 stated ULP-B opened the window once because of R4's smoke. R1 stated they had seen R4 smoke on four separate occasions in the ALF. On January 23, 2024, at 12:21 p.m., RN-A stated to their knowledge there was a designated smoking area where residents could be visually monitored by staff. RN-A stated trash cans, clothes, and carpets were monitored for burn marks. RN-A stated if a resident was found smoking inside the ALF, the resident would be given a warning and the incident would be documented in the assessment. RN-A stated they were unaware of any resident smoking within the facility; however, they only worked on call and were not familiar with this facility. The licensee's undated Fire Safety Program for the Workplace policy indicated the facility was a no smoking environment. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in all indoor public places and indoor places of employment including health care facilities and clinics. In addition, vaping and smoking cannabis products was included in the definition of smoking under the MCIAA.	0 830			

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0 830	Continued From page 49 Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900			

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0 900	Continued From page 50 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 admitted to the licensee on October 15, 2023, and began receiving assisted living services. R4 previously discharged from the current licensee and transferred to a sister facility of the licensee (different Health Facility Identification Number (HFID)) and readmitted to the licensee on October 15, 2023. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of January 23,	0 900			

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0 900	Continued From page 51 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's record included a contract titled Resident Agreement signed August 1, 2021, provided to R4 by the licensee on a previous admission. R4's record lacked a current written contract with the required content provided by licensee upon admission. On January 25, 2024, at 12:38 p.m., agent (A)-C stated a new contract should be issued to the resident when a resident transfers facility. A-C stated they were unable to find a signed contract for the current admission. The licensee's undated Assisted Living Contracts indicated the facility will establish a contract with each client [resident] at the time of admission. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 900			
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	01290			

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01290	Continued From page 52 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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for six of 15 employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-D, ULP-G, ULP-I, office administrator (OA)-H). 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 January 24, 2024, at 7:24 a.m., the surveyor requested the licensee's Minnesota Department of Human Services NETStudy 2.0 roster for HFID 35639. On January 24, 2024, at 10:03 a.m., the surveyor compared the licensee's NETStudy 2.0 roster for HFID 35639 to the licensee's employee list. The surveyor observed RN-A, ULP-B, ULP-D, ULP-G,	01290			

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01290	Continued From page 53 ULP-H, and ULP-I were not listed on the roster. On January 24, 2024, at 11:47 a.m., the surveyor requested the NETStudy 2.0 roster for the entire company (to include any sister facilities). RN-A RN-A was hired on December 12, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. RN-A RN license was issued on September 9, 2014. RN-A's employee record contained a background study clearance dated December 12, 2018, affiliated to licensee's sister facility health facility identification (HFID) 32874. ULP-B ULP-B was hired on June 14, 2022, to provide direct services to residents. On January 22, 2024, at 1:20 p.m., the surveyor observed ULP-B administer medication to R1. ULP-B's employee record lacked a background study. On January 24, 2024, at 12:11 p.m., agent (A)-C stated the licensee conducted a background study prior to hire at the location they believed the employee would be placed. A-C stated if staff transferred to a different facility (any of the licensee's sister facilities), the licensee would affiliate the employee to the new the HFID. The surveyor inquired why employees were not affiliated with the HFID 35639. A-C stated "oh man that was a lot of misses. I will work on that."	01290			

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01290	Continued From page 54 On January 24, 2024, at 12:16 p.m., the surveyor reviewed the NETStudy 2.0 roster for the entire company and observed the following employees affiliated to licensee's sister facilities: - RN-A affiliated to HFID 32874; - ULP-B affiliated to HFID 36870; - ULP-D affiliated to HFID 32874; - ULP-G affiliated to HFID 36870; - OA-H affiliated to 39329 and 99329; and - ULP-I affiliated to 36870. The licensee's employee list dated January 22, 2024, indicated RN-A, ULP-B, ULP-D, ULP-G, OA-H and ULP-I were all current employees of the licensee. The licensee's undated Background Studies policy indicated each facility employee, volunteer or contractor who would provide direct care to residents must have a background study completed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01470 SS=D	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;	01470			

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NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01470	Continued From page 55 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or 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	01470			

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01470	Continued From page 56 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A was hired on December 12, 2018, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. RN-A's employee record included an overview of home care statutes, home care bill of rights, review of types of home care services employee would provide and scope of services, providers policies and procedures, handling emergencies, reporting maltreatment, and handling complaints completed on November 27, 2018. RN-A's	01470			

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01470	Continued From page 57 employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: - an overview of this assisted living statutes; - assisted living bill of rights; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. On January 25, 2024, at 11:19 a.m., RN-A stated the licensee did not provide education on the topics listed above. RN-A stated they only provide on-call coverage to the facility when it is needed. RN-A stated the licensee familiarized them with the facility and how to cover the facility in an emergency instance. In addition, RN-A stated the licensee hired them based on their experience and they "figured I already do know." The licensee's undated Facility Employee Orientation policy, did not address the requirements of current licensure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500			

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01500	Continued From page 58 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500			

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01500	Continued From page 59 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A was hired on December 12, 2018, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. RN-A's employee record included a pediatric advanced life support (PALS) certificate completed December 14, 2023, and a vulnerable adult course completed February 4, 2022. RN-A's	01500			

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01500	Continued From page 60 record did not include further trainings from 2019, 2020, 2021, 2022, or 2023. RN-A's employee record lacked eight hours of annual training completed within the last 12 months for: - reporting maltreatment of vulnerable adults; - infection control; - assisted living bill of rights; - review of provider policies and procedures; - principles of person-centered planning/service delivery; and - dementia training (two hours required). On January 25, 2024, at 11:19 a.m., RN-A stated the licensee did not provide them with annual training and they transferred their education from a different place of employment. RN-A stated they only provided on-call coverage to the licensee. The licensee's undated Annual Training Requirements policy read, "All staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment. The training must be obtained from the home care [assisted living] provider or another source and must include topics relevant to the provision of assisted living services." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530			

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01530	Continued From page 61 (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-B, ULP-E). In addition, the licensee failed to ensure a supervisor of direct-care employees received at least two hours of training on topics related to dementia for each 12 months of employment thereafter for one of three employees (registered nurse (RN)).	01530			

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01530	Continued From page 62 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at 10:02 a.m., during entrance conference, agent (A)-C stated they were aware of the contents of the employee record and employee records were stored in paper format in the cooperate office. A-C stated the office recently had a fire however, no documents were destroyed. ULP-B ULP-B began employment on June 14, 2022, to provide direct services to residents. ULP-Bs employee record included five hours of initial training on dementia completed on June 15, 2022. The employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. On January 25, 2024, at 10:19 a.m., the surveyor attempted to interview ULP-B about trainings and competencies. ULP-B stated, "Yes competency for meds by a nurse we do with a nurse. These are professional people the rest you can do with the company. I am going home I need to sleep." ULP-B then exited the facility. ULP-E ULP-E began employment on September 20,	01530			

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01530	Continued From page 63 2022, to provide direct services to residents. ULP-E's employee record transcript included five hours of initial training on dementia completed on September 21, 2022. The employee record lacked the required eight hours of dementia training to be completed with 160 hours of employment. On January 25, 2024, at 9:57 a.m., ULP-E stated training was completed in person which consisted of four hour per day for three days. The surveyed asked how many hours were spent on dementia training. ULP-E stated the dementia topic was about 45 minutes to an hour. ULP-E stated they were a full-time employee. RN-A RN-A's record lacked two hours of the dementia care training for each 12 months of employment. In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42 a.m., and January 25, 2024, at 11:13 a.m., requesting to see full employee records for RN-A, ULP-B and ULP-E. On January 25, 2024, at 9:50 a.m., agent (A)-C stated they were unable to locate further employee records for RN-A, ULP-B, and ULP-E. On January 25, 2024, at 11:35 a.m., the surveyor inquired to registered nurse (RN)-A the total number of hours that are offered to new staff. RN-A stated they were offered eight hours of dementia training, so they assume other staff were offered the same number of hours.	01530			

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01530	Continued From page 64 The licensees undated Qualification, Training and Competency policy indicated the licensee shall provide training to all staff providing and supervising assisted living services at the time of hire, and as needed to meet state guidelines and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640			

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01640	Continued From page 65 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of three residents (R1, 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). The findings include: R1 R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's unsigned service plan Service Plan (Wavier) - Addendum to Contract effective date January 4, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. On January 22, 2024, at 1:20 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R1. R4	01640			

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01640	Continued From page 66 R4 admitted to the licensee on October 17, 2023, and began receiving assisted living services. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of January 23, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R1 and R4's service plans lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided. On January 22, 2024, at 10:02 a.m., during entrance conference, agent (A)-C stated they were aware of the contents of the employee record and employee records were stored in paper format in the cooperate office. A-C stated the office recently had a fire however, no documents were destroyed. On January 22, 2024, at 1:03 p.m., registered nurse RN-A stated the clinical nurse supervisor (CNS) was unavailable and unreachable to assist during the survey. In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42 a.m., and January 25, 2024, at 11:13 a.m., requesting R1 and R4's signed service plan. On January 25, 2024, at 11:36 a.m., registered nurse (RN)-A stated service plans were signed on	01640			

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01640	Continued From page 67 admission and when there was an acute change in condition. In addition, RN-A stated the CNS may have the signed service plan located in a folder they do not know about because they were "old school." RN-A stated, "some nurses just don't trust the computer." On January 25, 2024, at 11:56 a.m., A-C stated they were unable to locate a signed service plan for R1. In addition, A-C stated they were able to locate a signed service plan from a previous admission, however, was unable to locate a service plan from the admission in October 2023. The licensee's undated Service Plan policy indicated the service plan and any revision must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting the agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(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
01730	Continued From page 68 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an accurate individualized medication management record for each resident to include all required content for one of three residents (R4). This practice resulted in a level two violation (a	01730			

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01730	Continued From page 69 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: R4 admitted to the licensee on October 15, 2023, and began receiving assisted living services. R4 previously discharged from the current licensee and transferred to a sister facility of the licensee (different Health Facility Identification Number (HFID)) and readmitted to the licensee on October 15, 2023. R4 diagnoses include diabetes mellitus type 2, chronic kidney disease stage 3 (kidney failure), chronic pain (ongoing pain), osteoarthritis of the right knee (tissues breakdown in the joint), depression with anxiety, degenerative disc disease, and hypertension. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of January 23, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. On January 23, 2024, at 10:47 a.m., the surveyor observed two opened insulin pens in R4's chest of drawers.	01730			

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01730	Continued From page 70 R4's admission nursing assessment dated October 17, 2023, and 14-day nursing assessment dated October 31, 2023, indicated R4 required supervision and close monitoring of diabetic management due to non-compliance and staff would supervise R4 to ensure R4 completed blood glucose monitoring accurately and took insulin as prescribed. In addition, R4's uncontrolled medication would be secured in a locked medication room, R4 would access medication per schedule or as needed (PRN) by request. The surveyor requested R4's Individualized Medication Management Plan and received from agent (A)-C. A-C provided a document titled Individualized Medication Managmnt plan completed November 18, 2022, from R4's prior admission to the licensee, that indicated resident self-administered medications with staff reminders, took medications whole, nurse would assist with medication supplies and reordering as needed, medications were kept in a locked medication room, and staff would contact on call clinical director with any concerns to medications. The Individualized Medication Management Plan did not accurately reflect R4's storage of medications. On January 25, 2024, at 11:37 a.m. registered nurse (RN)-A stated R4 needed staff reminders for medication administration and medications were stored in R4's room. The surveyor inquired where the medication was stored in the room. RN-A stated they were unaware of how R4's medications were stored because they were an on-call nurse and R4 only wanted the clinical nurse supervisor (CNS) to assist them. The licensee's undated Medication Management	01730			

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01730	Continued From page 71 Services policy indicated based on the nursing assessment, the RN would develop and individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines and would develop specific procedures for medication management services that the staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-B, ULP-E) followed appropriate medication	01760			

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01760	Continued From page 72 administration procedures, which lead to a failure in administering medication according to prescriber's orders for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's diagnoses include borderline personality disorder, alcohol dependance uncomplicated, opioid dependence, insomnia, major depressive disorder, alcohol abuse with withdrawal, diaphragmatic hernia with obstruction or gangrene, pain in left shoulder, alcohol hepatitis with ascites (inflammation of the liver, fluid in abdominal area), psychoactive substance dependance, attention deficit hyperactivity disorder (ADHD) predominantly inattentive type, idiopathic aseptic necrosis of left ankle (unknown origin of infection, tissue death), post-traumatic stress disorder (PTSD), other mixed anxiety disorders, stress fracture left ankle, and moderate persistent asthma uncomplicated. R1's unsigned service plan Service Plan (Wavier) - Addendum to Contract effective date January 4, 2024, indicated R1 received assistance with	01760			

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01760	Continued From page 73 bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance. R1s unsigned orders indicated R1 received the following medications; amitriptyline hydrochloride 25 milligram (mg) by mouth daily, Biotin Oral Tablet 5000 microgram (mcg), Certavitamin one table by mouth daily, cholecalciferol (vitamin D3) 25 mcg by mouth once daily, duloxetine capsules 60 (mg) by mouth daily, fluticasone propionate nasal suspension 50 mcg daily, fluticasone-salmeterol 100-60 mcg daily, gabapentin capsule 600 mg by mouth three times daily, hydrochlorothiazide 25 mg by mouth once daily, ibuprofen 600 mg by mouth three times daily, losartan potassium 650 mg by mouth once daily, magnesium oxide 400mg by mouth once daily, Methadose 5 mg by mouth three times daily, omeprazole-delayed release 40 mg by mouth twice daily, quetiapine 50 mg by mouth 2 p.m., quetiapine fumarate 10 mg by mouth once daily, rivaroxaban 10 mg by mouth daily, Thera M Plus 1 tablet by mouth daily, and vitamin E external oil 28000 units (U) apply to skin (topically) once daily. R1's medication administration record (MAR) dated January 1, 2024, through January 31, 2024, indicated R1 would be administered the following medications at 7:00 a.m., methadose 5 mg, 8:00 a.m.; biotin 5000 mcg, Certavitamin 1 tablet, cetirizine 10 mg, cholecalciferol 50 mcg, duloxetine 60 mg, fluticasone propionate nasal 50 mcg inhaler, fluticasone-salmeterol aerosol 100-50 mcg, gabapentin 1200 mg, hydrochlorothiazide 25mg, ibuprofen 50 mg, magnesium oxide 400 mg, Multivitamin-minerals 1 tablet, Thera M plus 1 tablet daily, and Vitamin	01760			

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01760	Continued From page 74 E external oil apply to skin. - The MAR indicated R1 would be administered the following medication at 1:00 p.m.; methadose 5 mg. - The MAR indicated R1 would be administered the following medications at 2:00 p.m.; gabapentin 1200 mg, ibuprofen 600 mg, and quetiapine 50 mg. On January 22, 2024, at 1:20 p.m., the surveyor observed ULP-B perform R1's medication administration for administration times of 1:00 p.m. and 2:00 p.m. ULP-B took the medication out from the medication closet, opened the safe, counted the remaining methadose tablets, punched one tablet of methadose into a medication cup. ULP-B documented the administration and remaining tablets of methadose in RTasks (documentation software). ULP-B then opened another screen in RTasks which included gabapentin 600 milligrams (mg) give 2 tablet, ibuprofen 600 mg, and quetiapine 50 mg. ULP-B removed the preset medication box, placed two tablets marked NT150 (gabapentin) from the preset box into the medication cup, and administered the three tablets of medication to R1. ULP-B then pressed complete at the bottom of the electronic medication administration record (EMAR) which indicated all medications listed above were administered. The surveyor did not observe ULP-B verify a medication count or verify the medications against the written orders in the EMAR. In addition, the surveyor did not observe ULP-B administer ibuprofen 600 mg or quetiapine 50 mg. On January 22, 2024, at 1:03 p.m., registered nurse (RN)-A stated the clinical nurse supervisor (CNS) was not available and was out of town.	01760			

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01760	Continued From page 75 On January 22, 2024, at 1:32 p.m., RN-A stated they did not train the staff at this assisted living facility (ALF), that was the responsibility of the CNS. RN-A stated they knew how medication administration should be completed however, they were not sure if it was being completed appropriately. RN-A stated they were only an on-call nurse at the facility. RN-A stated, "I would assume they were trained to see how many pills and that is the pills that should be given and if there is one missing click decline or contact the nurse and let them know it does not match." On January 22, 2024, at 1:27 p.m., ULP-B stated they were really nervous. On January 23, 2024, at 6:40 a.m., the surveyor entered the facility, observed ULP-E sitting at the dining table with medication cards. ULP-E stated the RN had instructed them to do medications differently and to contact the nurse if they did not understand. ULP-E looked at the medication names on the medication cards. ULP-E was observed looking at an electronic tablet. ULP-E stated, "the medication now comes in a bubble pack so have to check along in the bubble pack that it matches the one in the computer system." On January 23, 2024, at 7:05 a.m., the surveyor observed ULP-E perform hand hygiene and put gloves on. ULP-E punched out the following medications for R1 from a multi-pill bubble pack: biotin 5000 mcg tablet omeprazole 40 mg, quetiapine 50 mg, vit d3 25 mcg, certivite one tab, duloxetine 60 mg, magnesium oxide 400 mg into a medication cup. ULP-E picked up a medication card labeled certivite and punched one tablet into the medication cup. ULP-E looked at the electronic tablet, continuously scrolled up and	01760			

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01760	Continued From page 76 down on the list of medications for R1. ULP-E stopped using the electronic tablet, picked up the methadose medication card, counted the number of tablets and punched one tablet into the medication cup. ULP-E gave the medication cup to R1. R1 looked at the medication cup and requested two as needed (PRN) medications. R1 stated to ULP-E, "the Compazine yellow pill and the hydroxyzine, the new one that came in a paper bag." ULP-E started to look through R1's medication cards and found the Compazine 10 mg and hydroxyzine 25 mg medication cards. Without verifying the medication against then MAR, ULP-E punched the requested medication into the medication cup and handed the medication cup to R1. R1 stated, "looks like my gabapentin is missing". ULP-E started to look through R1's medication cards, found the gabapentin card and showed it to R1. Without verifying the medication against the MAR, ULP-E punched the requested medication in the medication cup. R1 was observed taking all tablets from the medication cup. ULP-E then opened the electronic medication administration record (EMAR) on the tablet clicked on "all complete" in Rtask. ULP-E then searched for the PRN section of the EMAR, located the hydroxyzine, and documented the medication was administered for anxiety. On January 23, 2024, at 7:28 a.m., the surveyor inquired where on the EMAR methadose was documented. ULP-E stated, "that is what I am looking for." On January 23, 2024, at 7:31 a.m., the surveyor observed ULP-E use a cell phone and call an unknown person. ULP-E stated to the person they wanted to chart the methadose but could not find the medication on the EMAR.	01760			

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01760	Continued From page 77 On January 23, 2024, at 7:36 a.m., ULP-E was still taking on the cell phone. ULP-E stated, "Found it in another spot". ULP-E documented in Rtask that methadose was administrated to R1. ULP-E stated they found the area to document the medication administration on the night shift for the methadose. The surveyor did not observe ULP-B verify a medication count or verify the medications against the written orders in the EMAR. The surveyor observed ULP-E document the following medications as administered to R1 however, the surveyor did not observe R1 receive the following medications; fluticasone-salmeterol aerosol 100-50 mcg/act, ibuprofen 600 mg, losartan potassium 50 mg, magnesium 400 mg, Zyrtec 10 mg and fluticasone propionate nasal 50 mcg/act. On January 23, 2024, at 7:38 a.m., ULP-E stated the RN instructed them on how to perform medication administration, by matching the name of the medication to what is listed in RTasks. ULP-E stated, "I only work here Tuesday morning." On January 23, 2024, at 7:49 a.m., the surveyor inquired to ULP-E how they were trained on medication administration for PRN medications. ULP-E stated they do not contact the nurse for PRN medications. ULP-E stated medications were given based on resident requests and symptoms and they would document if the medication were effective. On January 24, 2024, at 11:37 a.m., the surveyor inquired how staff were trained to administer medications. RN-A stated staff should attend a medication administration class and were they	01760			

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01760	Continued From page 78 are instructed to follow the five rights of medication administration. RN-A stated, "They are not supposed to ask the resident and I am only reinforcing the training, but I did come in after the first night after the med error". The licensee's undated Documentation of Medication Administration policy read, "Staff administering medications will verify the medications are set up correctly before administration to the client by using the medication profile. If there is any question whether the medications have been set up accurately, the staff will contact the nurse and will receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of two residents (R1, R3) who received medication administration by the licensee.	01820			

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01820	Continued From page 79 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 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's diagnoses include borderline personality disorder, alcohol dependance uncomplicated, opioid dependence, insomnia, major depressive disorder, alcohol abuse with withdrawal, diaphragmatic hernia with obstruction or gangrene, pain in left shoulder, alcohol hepatitis with ascites (inflammation of the liver, fluid in abdominal area), psychoactive substance dependance, attention deficit hyperactivity disorder (ADHD) predominantly inattentive type, idiopathic aseptic necrosis of left ankle (unknown origin of infection, tissue death), post-traumatic stress disorder (PTSD), other mixed anxiety disorders, stress fracture left ankle, and moderate persistent asthma uncomplicated. R1's unsigned service plan Service Plan (Wavier) - Addendum to Contract effective date January 4, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance.	01820			

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01820	Continued From page 80 R1's signed provider orders dated December 15, 2023, included Eucerin or other body lotion, bacitracin ointment, vitamin E oil, and bandages for R1 to self-administer. R1's Med Amin Summary- Actual- Month dated January 1, 2024, through January 31, 2024, indicated R1 received Methadose 5 milligrams (mg) three times per day, biotin 5000 micrograms (mcg) daily, certavitamin one tablet daily, Zyrtec 10 mg daily, cholecalciferol 50 mcg daily, duloxetine delayed release 60 mg daily, fluticasone propionate nasal suspension 50 mcg one spray into both nostrils daily, fluticasone-salmeterol aerosol powder breath activated 100 mg -50 mg inhale one puff two times per day, gabapentin 1200 mg three times per day, hydrochlorothiazide 25 mg daily, ibuprofen 600 mg every eight hours until January 27, 2024, losartan potassium 50 mg daily, magnesium oxide 400 mg twice a day, theram plus one tablet daily, amitriptyline hydrochloride 75 mg daily, omeprazole two times per day, quetiapine fumarate 100 mg daily, rivaroxaban 10 mg daily, and hydroxyzine 50 mg as needed (PRN) three time per day. R1's medical record lacked current signed provider orders for the medications listed above. R3 R3 was admitted to the licensee on October 2, 2023, and began receiving assisted living services. R3 diagnoses include Schizophrenia (delusions, false beliefs, hallucinations, unusual physical behavior, and disorganized thinking and speech), unspecified major depressive disorder, recurrent	01820			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 81 mild borderline personality disorder (may experience mood swings and emotional reactivity). R3 signed Service Plan (Waiver) - Addendum to Contract effective date January, 11, 2024 indicated R3 received assistance with bathing reminder, clinical monitoring, manage agitation, manage anxiety, manage physical aggression, manage verbal aggression, manage wandering, declutter room, dressing assistance, grooming reminder, housekeeping, laundry, manage behavior - auditory hallucinations, depression, elopement, visual hallucinations, medication set up and monitoring, medication administration, and vital signs (VS). R3's Med Admin Summary- Month dated January 1, 2024, through January 31, 2024, indicated R3 received gabapentin 800 mg three times per day, lithium carbonate extended release 450 mg daily, Risperdal 2 mg twice per day, sertraline 200 mg daily, melatonin 3 mg daily, olanzapine 20 mg daily, prazosin 1 mg daily, and trazadone 300 mg PRN at bedtime. R3's medical record lacked current signed provider orders for the medications listed above. On January 22, 2024, at 10:02 a.m., during the entrance conference, agent (A)-C stated resident records were stored electronically and in paper format in the cooperate office. A-C stated the office recently had a fire however, no documents were destroyed as documents. In addition to verbal requests, the surveyor emailed the licensee on January 22, 2024, at 2:44 p.m., January 24, 2024, at 7:28 a.m., January 24, 2024, at 4:20 p.m., January 25, 2024, at 6:42	01820			

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01820	Continued From page 82 a.m., and January 25, 2024, at 11:13 a.m., requesting R1's signed provider orders. In addition to verval requests, the surveyor emailed the licensee on January 24, 2024, at 4:02 p.m., and January 25, 2024 , at 6:55 a.m., requesting R3's signed provider orders. On January 25, 2024, at 11:42 a.m. registered nurse (RN)-A stated orders should be renewed with changes and yearly and should be located in the medical record. RN-A stated they were unaware of why the licensee was unable to find the provider orders as they were an "on-call" nurse. On January 25, 2024, at 11:50 a.m., A-C stated they were unable to locate provider orders for R3 and they were only able to locate the signed orders mentioned above signed December 15, 2023, already provided to the surveyor for R1. The licensee's updated Medication Prescriptions and Refills policy indicated a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff was responsible for setting up the medication, administering the medication, or providing other medication management services for a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890			

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01890	Continued From page 83 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 medications were maintained with the original prescription drug label for one of two residents (R1). The licensee failed to discard expired medication for one of two residents that received medication dispensing services (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on December 7, 2023, and began receiving assisted living services. R1's unsigned service plan Service Plan (Wavier) - Addendum to Contract effective date January 4, 2024, indicated R1 received assistance with bathing, bedmaking, behavior management, dressing, grooming, housekeeping, laundry, meals, medication administration, vital sign, safety check, and shopping assistance.	01890			

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01890	Continued From page 84 R1's Medication administration record dated January 1, 2024, through January 31, 2024, indicated R1 received duloxetine 60 mg daily, and rivaroxaban (Xarelto) 10 mg daily. On January 22, 2024, at 11:38 a.m., the surveyor observed the medication closet and observed the following expired medications: - R1 duloxetine 60 mg expired November 29, 2023, famotidine 20 mg expired November 30, 2023, Xarelto 10 mg expired December 20, 2023. On January 22, 2024, at 11:39 a.m., the surveyor observed the medication closet and observed the follow medications with illegible prescription labels: - R1's medication card lacked an intact medication prescription label from the pharmacy and contained 3 teal and white oblong capsules; and - R1's medication bottle with unreadable faded prescription label. On January 22, 2024, at 11:39 a.m., agent (A)-C stated, "that's omeprazole but I see what you mean, yep you're right, I'm going to call [the pharmacy]." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910			

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01910	Continued From page 85 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01910			

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01910	Continued From page 86 a large portion or all of the residents). The findings include: R2 R2 was discharged from the licensee on November 18, 2023. R2's diagnoses included quadriplegia, stage four pressure ulcer to the sacral region, acute and chronic respiratory failure with hypoxia, gangrene and necrosis of the lung, tracheostomy status, hypertension, asthma, depression, anemia, neurogenic bowel (inability to control defecation due to a deterioration of or injury to the nervous system), and cardiac arrest. R2's Discharge - Transfer Summary printed on January 1, 2023, indicated the licensee administered the following medication to R2: acetaminophen 650 milligrams (mg) four times per day, Duo-Neb 2.5 mg/5 mg two times per day, aspirin 81 mg chewable tablet once a day, atorvastatin 40 mg once a day, baclofen 30 mg four times per day, bupropion extended release 300 mg once a day, diclofenac topical gel 1 percent (%) 2 grams (g) four times per day, Enemeez 283 mg/5 milliliters (ml) once per day, colace 100 mg twice per day, ferrous sulfate 65 mg twice per day, folic acid 400 mg once a day, ketamine hydrochloride 0.3 ml-1 ml four times per day, lidocaine 4 % topical patch once a day for 12 hours, loratadine 10 mg once a day, melatonin 3 mg once a day, Tab-A-Vite 0.4 mg once a day, prazosin 6 mg once per day, pregabalin 200 mg three times per day, quetiapine 50 mg once a day, sennosides 8.6 mg four tablets once a day, tizanidine 4 mg once a day, and tizanidine 2 mg twice a day. In addition, the document included a section for medication disposition summary	01910			

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01910	Continued From page 87 however, contained no information. On January 22, 2024, 2:44 p.m., the surveyor requested R2's medication disposition record. On January 23, 2024, at 8:33 a.m., the surveyor requested R2's medication disposition record. On January 24, 2024, at 7:28 a.m., the surveyor requested R2's medication disposition record. On January 24, 2024, at 4:20 p.m., the surveyor requested R2's medication disposition record. On January 25, 2024, at 6:42 a.m., the surveyor requested R2's medication disposition record. On January 25, 2024, at 9:48 a.m., agent (A)-C stated R2 discharged to a different facility, and the licensee provided R2 their medication. In addition, A-C stated they were unable to locate a medication disposition record and believed it was sent with R2 to the new facility. On January 25, 2024, at 11:48 a.m., registered nurse (RN)-A stated the medication disposition record should be documented in RTasks (a documenting software program) if the resident received medications from the licensee's choice pharmacy. If the resident did not receive medication from the licensee's choice pharmacy, the medication disposition would be in paper format. RN-A stated if the medication was sent with the resident, the licensee should make a copy of the medication disposition and provide one to the resident or resident representative and keep one for the medical record. RN-A stated the medication disposition should include the medication name, prescription number, the amount remaining, and person that disposed the	01910			

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01910	Continued From page 88 medication or who received the medication. RN-A stated they were unable to locate R2's medication disposition record because it was not in the medical record where they believed it should be located. R5 R5 discharged from the licensee on September 29, 2023. R5's diagnoses included chronic obstructive pulmonary disease (COPD), and diabetes. R5's Med Amin Summary - Month dated September 1, 2023, through September 30, 2023, indicated the following medications were administered to R5 by the licensee's staff: aspirin 81 mg once a day, docusate 100 mg twice a day, ferrous sulfate 65 mg once a day, gabapentin 300 mg three times per day, glipizide 5 mg twice a day, metoprolol 100 mg once a day, rivaroxban 15 mg once a day, sertraline 50 mg once a day, and torsemide 50 mg twice per day. R5's Discharge - Transfer Summary completed October 2, 2023, included a section for medication disposition summary however, contained no information. On January 25, 2024, at 11:48 a.m., the surveyor requested R5's medication disposition record. RN-A attempted to locate items within RTasks. On January 25, 2024, at 11:56 a.m., RN-A stated R5's medications were transferred with R5. RN-A stated the discharge summary showed the medications that were transferred with the resident under the medication section however, lacked a quantity that was provided to R5.	01910			

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01910	Continued From page 89 The licensee's undated Medication Disposition or Disposal policy read, "a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose, and the amount of medication remaining. c. When the resident and/or family do not take the medications with them, the facility will dispose of the medications following the steps outlined below. Medications to be disposed of will be listed, counted, and the person disposing of the medications "Will sign the note/form. This documentation will be in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940			

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01940	Continued From page 90 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 observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of one resident (R4) who received treatments. 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	01940			

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01940	Continued From page 91 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: R4 admitted to the licensee on October 17, 2023, and began receiving assisted living services. R4's unsigned Service Plan (Wavier) - Addendum to Contract with effective date of January 23, 2024, indicated R4 received assistance with appointments, bathing, housekeeping, laundry, behavior management, socialization, continuous positive airway pressure (cpap)/bilevel positive airway pressure (bipap), cpap/bipap supervision, dressing, grooming, meals, medication reminders, vital signs, transfer assist, transportation, and ambulation assistance. R4's provider orders signed June 29, 2023, included cpap/bipap, on in the evening, off in the morning every day. On January 23, 2023, at 10:51 a.m., the surveyor did not see a cpap/bipap in R4's room. The surveyor inquired about the cpap/bipap. R4 stated they don't have one, and they needed to get a new cpap/bipap machine. R4 stated the old machine had a lot of things going through it, and he no longer used it. R4's Services Delivered - One Resident dated January 1, 2024, to January 25, 2024, indicated in the a.m. staff supervised the cpap/bipap, and in the evening staff assisted with the cpap/bipap. The document included 19 declines by the R4, the document indicated the service were charted as "done earlier in the evening". In addition, the document included a total of four completed	01940			

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01940	Continued From page 92 cpap/bipap services evenings, and four supervisions completed in the morning. R4's 14-day assessment completed on October 31, 2023, indicated R4 independently used a bipap. R4's Individualized Treatment and Therapy Plan dated January 22, 2024, included the following: - treatment/ therapy: cpap/bipap; - service frequency: daily; - staff to perform / details: ULP (unlicensed personnel) on in the evening off in the morning; and - supervised by / details: cpap/bipap machines use a hose and mask or nosepiece to deliver constant and steady air pressure. Nurse will monitor for common problems with cpap/bipap which include a leaky mask, trouble falling asleep, stuffy nose, and dry mouth. R4's individualized treatment management plan comprised of multiple records lacked the following required content: - an accurate statement of the type of services that will be provided; and - procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatment or therapies. On January 25, 2023, at 9:44 a.m., unlicensed personnel (ULP)-E stated R4 did not use their cpap machine. On January 25, 2023, at 12:00 p.m., RN-A stated R4 used the cpap machine and staff provided reminders to resident. The licensee's undated Treatment and Therapy Management Plan policy read, "When the	01940			

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01940	Continued From page 93 resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented f. Frequency of supervision of personnel providing the delegated treatment or therapy services g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions h. The treatment or therapy plan will be updated when there are changes i. The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090			

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NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 94 (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at 8:21 a.m., upon entering the assisted living facility (ALF), the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On January 22, 2024, at 1:34 p.m., agent (A)-C stated the licensee did not use electronic monitoring in the facility. A-C stated they were aware of the requirement however, they believed the electronic monitoring notice was only required	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 95 to be posted if the licensee used electronic monitoring in the facility. The licensee's undated Electronic Monitoring policy with an effective date January 1, 2020, indicated the facility complies with the Minnesota Electronic Monitoring law. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: 01/22/24
Time: 12:12:13
Report: 7994241010

Food and Beverage Establishment Inspection Report

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Location:

Angel'S Health & Hc Srv Inc
4213 63rd Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038837
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632705771
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B **** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

CURRENT DISHWASHER DOES NOT HAVE A SANITIZING CYCLE. THE FACILITY HAS ORDERED AN APPROVED DISHWASHER WHICH SHOULD ARRIVE SOON.

Comply By: 01/22/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CURRENT CFPM WAS FOUND ON SITE.

Comply By: 01/29/24

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

PORKCHOPS FOUND THAWING ON THE COUNTER. THAW AS DESCRIBED ABOVE.

Comply By: 01/22/24

Type: Full
Date: 01/22/24
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Angel'S Health & Hc Srv Inc

Food and Beverage Establishment Inspection Report

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6-200 Physical Facility Design and Construction

6-202.13B

MN Rule 4626.1385B Relocate insect control devices so they are not over food preparation areas or in areas where dead insects or fragments can fall onto exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles.

FLY TAPE FOUND IN KITCHEN AREA. MOVE THESE OUTSIDE OF KITCHEN AREA.

Comply By: 01/22/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. MULTIPLE RESIDENTS COOK THEIR OWN FOOD.

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241010 of 01/22/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us