



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery
February 7, 2024

Licensee
Metro Assisted Living
2307 Ericon Drive
Brooklyn Center, MN 55430

RE: Provisional Conditional License Number 409795
Health Facility Identification Number (HFID) 39371
Project Number(s) SL39371015

Dear Licensee:

On December 20, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 28, 2023. The follow-up survey completed on December 20, 2023, found the facility to not be in substantial compliance.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction order issued pursuant to the last survey completed on September 28, 2023, found not corrected at the time of the follow-up survey follow-up survey is as follows:

- **0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)**

The details of the violations noted at the time of this follow-up survey completed on December 20, 2023 (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.

On January 24, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found not corrected at the time of the follow-up survey completed on December 20, 2023, pursuant to the survey completed on September 28, 2023. The January 24, 2024 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 24, 2024.

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

Effective January 24, 2024, MDH is granting your assisted living facility license. Your license number is 409795. You will not receive a replacement license certificate until your license is due to renew. If you have not received a letter from us with information regarding renewing your license within 45 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.Homecare@state.mn.us.

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

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,

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

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL39371015-1 On December 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 28, 2023. At the time of the survey, there were no active residents receiving services under the Provisional Assited Living license. As a result of the revisit, the following orders were reissued. On January 24, 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued on December 20, 2023. Metro Assisted Living was found to be in substantial compliance with state regulations.	{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.		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	{0 550}			

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: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 550}	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action needed.	{0 550}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	{0 630}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 630}	Continued From page 2 by: No further action needed.	{0 630}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action needed.	{0 640}			
{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	{0 650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 650}	Continued From page 3 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: No further action needed.	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 660}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 680} 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: No further action needed.	{0 680}			
{0 820} SS=D	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	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 820}	Continued From page 5 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. The licensee failed to have an egress window that met minimum size requirements for one of one unoccupied resident room. 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: Unoccupied Resident Room On a facility tour on December 20, 2023, at 12:15 p.m., with licensed assisted living director/ owner (LALD/O)-A, it was observed unoccupied resident room #3's existing emergency escape and rescue opening did not meet minimum clear opening requirements. The window opening measured	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 820}	Continued From page 6 17.25 inches (in.) high by 33.5 in. wide with 578 square inches clear area. The window did not meet the minimum dimension of 20 in. clear height and did not meet the minimum clear opening area of 648 square inches. On December 20, 2023, at 12:15 p.m., LALD/O-A accompanying on the tour stated a replacement emergency escape and rescue window was ordered on November 1, 2023, and arrived December 14, 2023, but was not the required minimum size. It was also stated by LALD/O-A another window was ordered on December 14, 2023, with an expected delivery date of January 25, 2024, to replace the window that arrived and was not the required minimum size. On January 24, 2024, the surveyor conducted a follow-up visit and verified resident room #3 was in compliance with minimum measurement requirements for egress windows. This licensing order was corrected.	{0 820}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	{01060}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01060}	Continued From page 7 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (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: No further action needed.	{01060}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01620}	Continued From page 8 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action needed.	{01620}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	{01640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01640}	Continued From page 9 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action needed.	{01640}			
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 10	{01760}			
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy 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	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01940}	Continued From page 11 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: No further action needed.	{01940}			
{01950} SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the	{01950}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01950}	Continued From page 12 ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}			
{01960} SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action needed.	{01960}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2024
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{02310}	Continued From page 13 No further action needed.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

October 27, 2023

Licensee

Metro Assisted Living

2307 Ericon Drive

Brooklyn Center, MN 55430

RE: Conditional License Number 409795
Health Facility Identification Number (HFID) 39371
Project Number(s) SL39371015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 28, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b) is issuing a 90-day conditional provisional license due to expire on **January 25, 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, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

CONDITIONAL LICENSE ISSUED:

MDH will issue Metro Assisted Living a conditional provisional 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 Metro Assisted Living is in substantial compliance.

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

- a. **Egress window requirements:** Metro Assisted Living will replace at least one window in occupied bedroom number three, with egress windows that meet minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress.

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

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

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. The request for reconsideration should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

A handwritten signature in black ink that reads "Maria King". The signature is written in a cursive style with a large, stylized "M" and "K".

Maria King, RN
Division Director

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: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39371015 On September 25, 2023, through September 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no active residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550			

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: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 1 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 25, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. The surveyor did not observe a grievance procedure posting to include the contact information for the	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 2 Office of Ombudsman for Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to MAARC in the common's area of the facility. On September 25, 2023, at 11:23 a.m., LALD/O-A stated the above information was not posted as required. LALD/O-A added, "missed it" (required posting requirement). The licensee's Complaint/Grievance Posting policy, dated July 25, 2022, noted the facility would post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individuals (s) who were responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
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.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated R1 received services which included activity assistance, ambulation assist, appointment reminder, bathing assistance, behavior monitoring, denture care, dressing assist, escort assist, grooming, meal assistance, medication administration, oxygen management, monitoring blood glucose, blood pressure monitoring, oxygen monitoring, temperature monitoring, transfer assist, laundry and housekeeping.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 4 R1's IAPP dated June 3, 2023, identified R1 was not at risk to be abused. R1's record did not include an IAPP which assessed the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. On September 26, 2023, at 10:01 a.m., clinical nurse supervisor (CNS)-D stated licensed assisted living director/owner (LALD/O)-A was the person to ask about R1's IAPP. On September 26, 2023, at 12:18 p.m., R1's IAPP was reviewed with LALD/O-A. LALD/O-A stated he was not aware of "that" (requirement) and confirmed R1's IAPP did not include the required information. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted the facility developed and implemented an IAPP for each vulnerable adult. All residents in an assisted living were categorically considered vulnerable adults. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. 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 included self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 5 days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number and contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas on the main floor of the facility. This had the potential to affect 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).	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 640	Continued From page 6 The findings include: On September 25, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. The surveyor did not observe the required postings of 911 emergency number or MAARC contact information on the main level of the facility. On September 25, 2023, at 11:25 a.m., LALD/O-A stated the 911 emergency number and the MAARC contact information was not posted on the main level of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 7 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on December 19, 2022, to provide assisted living services. ULP-B's employee record lacked competency for medication unplanned time away, and training and competencies for carbohydrate counting, renal diet, fluid restrictions, and FreeStyle Libre 2 blood sugar testing system. ULP-C ULP-C was hired on December 19, 2022, to provide assisted living services.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 8 ULP-C's employee record included training and competency worksheets for vital signs, medication administration-routes, blood glucose testing, and oxygen. The forms were dated December 19, 2022, and included ULP-C's name handwritten on the top of each form. All of the training and competency forms were blank (not marked with pass or fail and did not include evaluator signature/ registered nurse (RN), date, title). In addition, ULP-C's record did not include documentation for competency for medication unplanned time away, and training and competencies for carbohydrate counting, renal diet, fluid restrictions, and FreeStyle Libre 2 blood sugar testing system. On September 25, 2023, at approximately 12:00 p.m., clinical nurse supervisor (CNS)-D stated "carb" (carbohydrate) counting education was completed in a class adding documentation was not in each employee record. On September 25, 2023, at 2:15 p.m., licensed assisted living director/owner (LALD/O)-A stated ULP-C's initial training was done in a class and CNS-D must have forgotten to document that the training and competencies were completed, hence training documents were blank. LALD/O-A stated the other training's listed above were completed in a class type of platform adding documentation was not in each employee record. On September 28, 2023, at 2:29 p.m., LALD/O-A produced a training document, Meeting Fluid Goals Can Improve Quality of Life/ Basic Diet for People on Dialysis, dated December 23, 2022, which included ULP-B, ULP-C, and LALD/O-A's	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 9 names as trained by CNS-D. This document was not in ULP-B or ULP-C's record. The licensee's Employee Records policy dated August 1, 2021, noted employee records for each person would include: -records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6 Training records and documentation, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 10 (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included the completion	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 11 of baseline TB screenings for two of two employees (unlicensed personnel (ULP)-B, ULP-C). In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test as required for two of two employees (ULP-B, ULP-C.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was dated December 18, 2022. The facility had been identified as low risk. TB SCREENING ULP-B ULP-B had a hire date of December 19, 2022. ULP-B's employee record included a blank Baseline TB Screening for Health Care Workers (HCWs). ULP-B's employee record did not include a completed Baseline TB Screening for HCW dated within 90 days of hire. ULP-C ULP-C had a hire date of December 19, 2022.	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 12 ULP-C's employee record included a completed Baseline TB Screening for HCW dated June 28, 2021. ULP-C's employee record did not include a completed Baseline TB Screening for HCW dated within 90 days of hire. TST/ BLOOD TEST COMPLETION ULP-B ULP-B's employee record did not include an IGRA (serum blood test) or TST (first step) dated within 90 days of hire. ULP-C ULP-C's employee record contained a QuantiFERON-TB- Gold blood test completed on June 21, 2021. ULP-C's employee record did not include a IGRA or TST dated within 90 days of hire. On September 25, 2023, at 1:57 p.m., licensed assisted living director/owner (LALD/O)-A stated ULP-B's record did not include a completed TB screening, adding, "that is all me", (responsibility). LALD/O-A said ULP-B had been given the choice of which TB test was completed, adding ULP-B told LALD/O-A she had a TB test completed. LALD/O-A stated ULP-B had been instructed to email the results to LALD/O-A. LALD/O-A said ULP-B never emailed the TB results to LALD/O-A, adding ULP-B no longer worked at the facility. LALD/O-A asked to have another staff member's TB screening and test reviewed. On September 25, 2023, at 2:35 p.m., LALD/O-A stated he was unaware ULP-C's TB screening and testing needed to be completed within 90	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 13 days of hire, adding ULP-C worked at the "sister" facility. LALD/O-A said it made no sense to pay for the TB testing twice. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, February 3, 2022, screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The licensee's Tuberculosis Screening policy dated August 1, 2021, noted staff whose essential job functions require work within the same air space of home care clients (residents) would be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening would be completed: -new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs -new staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs -no staff would be permitted to begin work where the work involved sharing the air space with residents until the negative results of the first Mantoux were read and documented or a negative IGRA blood test result was reviewed and documented -Staff TB screening results would be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 14	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. This had the potential to affect 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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 15 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 25, 2023, at 11:09 a.m., at the conclusion of the entrance conference, licensed assisted living director/owner (LALD/O)-A stated the facility's EPP was "right here" pointing to a binder positioned on a staff desk in the basement/lower level of the facility. On September 25, 2023, at 11:26 a.m., during a tour of the facility LALD/O-A stated the EPP is "usually, right here" pointing to a side table in the common's/living area near the entrance of the facility. LALD/O-A added he took "it" (EPP) downstairs. On September 25, 2023, at 2:37 p.m., a review of the facility's EPP was started with LALD/O-A. The licensee's undated EPP failed to include the following: - development of policies/procedures to address: - procedure for tracking staff and residents. On September 26, 2023, at 1:24 p.m., LALD/O-A stated the facility's EPP did not contain all of the required information, adding he had not developed a policy or procedure for tracking residents and on duty staff. In addition, LALD/O-A said the EPP was not in a prominent area at the time of the survey entrance, adding there was no signage of the EPP's location	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 16 posted in the facility. The licensee's Emergency Preparedness policy dated August 1, 2021, noted the Emergency Disaster Plan was prominently posted on each floor of the facility. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, noted, it is the intent the facility had in place an effective and compliant Emergency Preparedness Plan. The intent being the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 17 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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). Findings include: A record review of available documentation and interview were conducted on September 28,	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 18 2023, at approximately 12:45 p.m. of documents provided by licensed assisted living director/owner (LALD/O)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide room numbers identifying the resident rooms on or adjacent to the door of the rooms. Resident room numbers are required to be installed on or adjacent to the resident room doors to be used in conjunction with the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that the licensee did not include employee actions required in the event of a fire or similar emergency for this specific facility. Employee actions required during a fire or similar emergency are required to be developed and included in the fire safety and evacuation plan for this specific facility. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents of this specific facility in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 19 Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. Record review of the available documentation indicated on a spreadsheet with dates that evacuation drills had been conducted but no supporting documentation was provided for content of drills and who attended. Evacuation drills are required to be documented separately from employee training records. All deficiencies were verified by LALD/O-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 820	Continued From page 20 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedroom #3 with required existing emergency escape and rescue openings of minimum size. This bedroom is not occupied and did not directly affect any residents but has the potential to affect a resident. 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). Findings: On September 28, 2023, at approximately from 1:00 p.m., survey staff toured the facility with the licensed assisted living director/ owner (LALD/O)-A. On the tour it was observed that an existing emergency escape and rescue opening	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 21 with minimum required clear opening dimensions was not provided within unoccupied resident room #3. The clear opening of the window in the room identified as resident bedroom #3 measures 17.25 inches high and 33.5 inches wide. Emergency escape and rescue openings in existing sleeping rooms are required to have a minimum openable area of 648 square inches (4.5 square feet) total, clear opening minimum width of 20 inches and clear opening minimum height of 20 inches. Resident bedroom #3 is identified on the main floor of the provided fire safety and evacuation floor plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of 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	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 22 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). 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	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 23 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 Discharge or Deceased Resident Roster: State Evaluations form dated May 31, 2023, indicated R1 was admitted on December 20, 2022, and was discharged on May 21, 2023. R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated the resident received services which included activity assistance, ambulation assist, appointment reminder, bathing assistance, behavior monitoring, denture care, dressing assist, escort assist, grooming, meal assistance, medication administration, oxygen management, monitoring blood glucose, blood pressure monitoring, oxygen monitoring, temperature monitoring, transfer assist, laundry, and housekeeping. R1's resident notes included: -May 14, 2023, 9:29 p.m., call placed to 911, resident was "taken away" and would be transported to hospital (name) -May 20, 2023, at 7:30 p.m., resident just admitted back to house from hospital on May 19, 2023. R1's record lacked a written notice that	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 24 contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four (4) days. On September 25, 2023, at 12:23 p.m., the question was asked if the OOLTC had been notified of R1's relocation for greater than four (4) days. Clinical nurse supervisor (CNS)-D looked at licensed assisted living director/owner (LALD/O)-A questioning if the OOLTC had been notified of R1's relocation. LALD/O-A stated the OOLTC had not been notified. On September 28, 2023, at 2:43 p.m., LALD/O-A stated it was CNS-D's job responsibility to complete the needed paperwork for R1's relocation. The licensee's Emergency Relocation policy dated July 25, 2022, noted in the event of an	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01060	Continued From page 25 emergency relocation, the facility would provide a written notice that contained, at a minimum: -the reason for the relocation -the names and contact information for the location to which the resident had been relocated and any new service provider -contact information for the Office of Ombudsman for Long Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities -if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility or a statement that a return date was not currently known, and -a statement that , if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The notice required would be delivered as soon as practicable to: -the resident, legal representative, and designated representative -for residents who received ho and community-based waiver services, the resident's case manger, and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the tacitly within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 26 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the registered nurse (RN) failed to conduct a comprehensive reassessment for one of one resident (R1) with a hospital return. 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:	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 27 R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated the resident received services which included activity assistance, ambulation assist, appointment reminder, bathing assistance, behavior monitoring, denture care, dressing assist, escort assist, grooming, meal assistance, medication administration, oxygen management, monitoring blood glucose, blood pressure monitoring, oxygen monitoring, temperature monitoring, transfer assist, laundry, and housekeeping. R1's record included an assessment dated April 27, 2023, and included: -Nutritional/hydration status: regular and diabetic diet (nonstarchy vegetables, fewer added sugars and refined grains, whole foods, lean meats), eats three (3) meals a day and sometimes snacks depending on sugar levels -Hydration status: fluid restriction -current fluid intake pattern: "stated takes most times 32 ounces a day due to kidney failure and fluid restriction". R1's resident notes included: -May 14, 2023, 9:29 p.m., call placed to 911, resident was "taken away" and would be transported to hospital (name) -May 20, 2023, at 7:30 p.m., resident just admitted back to house from hospital on May 19, 2023. Resident is in need of new scripts but has not made it to her primary doctor appointments due to several re-hospitalizations.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 28 R2's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -follow this diet upon discharge: combination diet renal diet (dialysis): low sodium/salt, protein, potassium, or phosphorus (mineral), 2 grams sodium diet (limit the total amount of sodium intake to 2 grams, or 2000 milligrams (mg) daily. R1's record lacked documentation of a reassessment by the RN following May 19, 2023, hospital return. On September 26, 2023, at 10:05 a.m., clinical nurse supervisor (CNS)-D stated "sometimes by the time I got there (facility) to do the assessment she (R1) was gone again." CNS-D confirmed a hospital reassessment had not been completed for R1's May 19, 2023, return to the facility. The licensee's Assessment Schedules policy dated August 1, 2021, noted: -ongoing resident reassessment and monitoring: date/timeframe: as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. In-person or via telecommunications if necessitated by geographic distance or urgent/unexpected circumstances -changes in client condition: date/timeframe: as indicated. In-person or via telecommunications if necessitated by geographic distance or urgent/unexpected circumstances -weekend and holiday assessment: date/time frame: on weekends or holidays when a current resident is ready to be discharged from the hospital and return to the facility. No further information was provided.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 29	01620		
	TIME PERIOD FOR CORRECTION: Seven (7) days			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plan was updated, including authentication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 30 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: SERVICE PLAN REVISION R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated the resident received services which included: -meal assistance three (3) times per day -monitoring blood glucose (BG) three (3) times per day -record weight daily -record weight monthly. BLOOD GLUCOSE TESTING R1's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -FreeStyle Libre 2 (BG meter) four (4) times daily (before meals and nightly). R1's service plan was not revised to include BG monitoring four (4) times daily. On September 26, 2023, at 10:29 a.m., clinical nurse supervisor (CNS)-D stated R1's service plan had not been updated to BG monitoring four (4) times daily.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 31 WEIGHTS On September 25, 2023, at 12:37 p.m., CNS-D stated R1 may have been on daily weights in the past, adding R1 had some swelling. Licensed assisted living director/owner (LALD/O)-A stated the facility does monthly weight monitoring and daily weight on R1's service plan was an error (typo). DIET/FLUID RESTRICTION R1's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -Combination diet renal diet (dialysis); two (2) gram NA (sodium) diet. R1's most current assessment dated April 27, 2023, included: -Nutritional/hydration status: regular and diabetic diet (nonstarchy vegetables, fewer added sugars and refined grains, whole foods, lean meats), eats three (3) meals a day and sometimes snacks depending on sugar levels -Hydration status: fluid restriction -current fluid intake pattern: "stated takes most times 32 ounces a day due to kidney failure and fluid restriction". R1's service plan dated December 22, 2022, did not include specialized diet/fluid restrictions. On September 26, 2023, at approximately 11:35 a.m., LALD/O-A confirmed R1's service plan did not include R1's specialized diet/fluid restrictions. SERVICE PLAN AUTHENTICATION R1's service plan dated December 22, 2022, did not include a signature or title of the facility's representative who completed the service plan, as required.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 32 The licensee's Service Plan policy dated July 25, 2025, (sic) noted the facility would implement and provide all services indicated in the service plan. Service plans and any revisions or updates would be entered into the resident's record, including notice of change in fees when applicable. The licensee's Resident Record- Information and Content policy dated August 1, 2021, noted: -all entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 33 (RN) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated services received included medication administration. R1's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -sevelamer HCl (ESRD), 800 mg, three (3) times daily with meals -sodium zirconium cyclosilicate (high potassium in blood/ESRD), 10 grams packet, one (1) time a day: Sunday, Monday, Wednesday, Friday. R1's medication administration record (MAR) dated May 1, 2023, through May 31, 2023, included: -sevelamer HCl 800 mg, three (3) times daily with meals	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 34 -sodium zirconium cyclosilicate, 10 grams packet, one (1) time a day: Sunday, Monday, Wednesday, Friday. On September 26, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-D stated R1's sevelamer HCl, sometimes came in a pill form and other times came in a powder, adding R1 was very complicated. CNS-D confirmed R1's MAR did not include specific instructions for this medication. On September 26, 2023, at 10:23 a.m., CNS-D was asked about instructions to follow for R1's sodium zirconium cyclosilicate 10 mg. CNS-D stated she could not remember how the medication was to be mixed. CNS-D reviewed R1's MAR using her phone and stated "that" medication was "on hold" and R1 never got the medication. CNS-D confirmed R1's MAR did not include instructions for staff to follow for sodium zirconium cyclosilicate administration. The manufactures instructions for sevelamer dated June 15, 2020, noted sevelamer comes as a tablet and as a powder for suspension to take by mouth. Follow the directions on your prescription label carefully and ask your doctor or pharmacist to explain any part you do not understand. Take sevelamer exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. The manufactures instruction for sodium zirconium cyclosilicate dated July 15, 2018, noted empty the packet into a cup of three (3) tablespoons (45 milliliter) or more of water: -stir and drink immediately -if any powder remains in the cup, add more water, then stir and drink -repeat as needed until no powder remains to be	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 35 sure you received the full dose. The licensee's Medication & Treatment-Administration Delegation policy dated August 1, 2021, noted when administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the facility would ensure the registered nurse had: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 36 Based on interview and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R1) who received medication management 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: R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated services received included medication administration. R1's medication administration record (MAR) dated May 1, 2023, through May 31, 2023, included: -gabapentin (neuropathy) (daily) take one (1) capsule (100 mg) by mouth every morning and two (2) tablets by mouth at bedtime, (order started May 9, 2023) -Lantus solution-glargine (long-acting insulin (daily) 100 unit/milliliter (ml) inject five (5) units subcutaneously (SQ) once daily for DM2 (diabetes) with diabetic chronic kidney disease in	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 37 the a.m., pen (7-8 a.m.), 7:00 a.m. -Lantus solution-glargine (long-acting insulin (daily) 100 unit/milliliter (ml) inject six (6) units subcutaneously (SQ) once daily for DM2 with diabetic chronic kidney disease in the a.m., pen (7-8 p.m.), 7:00 p.m. Note if not feeling well GIVE five (5) units. R1's after visit summary, electronically signed by a prescriber, dated May 19, 2023, included: -gabapentin 100 mg every morning -insulin glargine 100 units/ml five (5) units am (morning) and seven (7) units pm (evening). MEDICATION ERROR R1's MAR dated May 1, 2023, through May 31, 2023, had not been updated to reflect R1's most current order for Lantus. R1 received the incorrect dosage of Lantus: May 19, 2023 and May 20, 2023. In addition, MAR documentation noted: - May 6, 2023, R1 received five (5) unit of insulin at 700 p.m. MEDICATION ADMINISTRATION: TRANSCRIPTION/DOCUMENTATION ERROR R1's gabapentin (daily) take one (1) capsule (100 mg) by mouth every morning and two (2) tabs by mouth at bedtime, (order started May 9, 2023) entry included documentation: -given May 10, 22, 12, 13, 14 -on hold May 15, 16, 17, 18, 19 -given May 20, 21. R1's MAR dated May 1, 2023, thorough May 31, 2023, had not been updated to reflect R1's most current order for gabapentin. On September 26, 2023, at 12:22 p.m., R1's May	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 38 MAR was reviewed with licensed assisted living director/owner (LALD)-A who stated "they" (facility) had a nurse on call 24/7, adding, if a person (resident) goes to ED (emergency department) the orders need to be put into place at the time of return. On September 28, 2023, at 12:53 p.m., clinical nurse supervisor (CNS)-D stated R1's was very complex and "insulin changed frequently and sometimes the pharmacy would have different orders that needed verification as the pens would read differently than the MAR and this needed correction." CNS-D added R1 was readmitted back to the facility but no verification was completed before she readmitted back to the hospital and unfortunately passed away. CNS-D did not address "if not feeling well GIVE 5 units." In addition, CNS-D stated gabapentin was initially ordered twice a day, but it had changed to once a day and she made a change to this, as reflected on the MAR. CNS-D confirmed she did not change description on the MAR for gabapentin from twice a day to once a day. The licensee's Medication management Individualized Plan policy dated August 1, 2021, noted the medication management record would be current and updated when there were any changes and medication reconciliation would be competed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 39	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1)	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 40 who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 25, 2023, at 10:58 a.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided treatment and therapy services to residents at the facility. R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated the resident received services which included: -meal assistance three (3) times per day -monitoring blood glucose (BG) three (3) times per day. R1's most current assessment dated April 27, 2023, included: -Nutritional/hydration status: regular and diabetic diet, eats three (3) meals a day and sometimes snacks depending on sugar levels -Hydration status: fluid restriction	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 41 -current fluid intake pattern: stated takes most times 32 ounces a day due to kidney failure and fluid restriction. R1's after visit summary, electronically signed by a prescriber, dated May 19, 2023, included: -Combination diet renal diet (dialysis); two (2) gram NA (sodium) diet -insulin Aspart (short acting) 100 unit/milliliter (ml) pen, take with snacks or supplements for high blood sugar. Take 1 unit for every 15 carbohydrates (carb) with every meal and snack. R1's Record-Meal Assistance-task sheet dated active on December 21, 2022, included: -provide any needed assistance at mealtime (specify): Resident is on a low sodium diet aimed at reducing sodium intake due to kidney disease. When preparing and serving the residents meals, limit high-sodium foods like processed foods, salty snacks, canned goods, and certain seasoning. Serve fresh fruits, vegetables, whole grains, lean proteins, and carefully portioned low-sodium alternatives. R1's medication administration record (MAR) dated May 1, 2023, through May 31, 2023, included: -insulin Aspart (daily) inject 1-7 units subcutaneous, take with snacks or supplement for high blood sugar. -administer one (1) unit per 15 grams of carbs with all snacks and two (2) units per 30 grams carbs and so on. -"I" (clinical nurse supervisor /CNS-D) put in all the available times, use whichever time works when she is taking snacks. Times entered on R1's May MAR for insulin Aspart 1-7 units with snacks or supplements included: 6:00 a.m., 10:00 a.m., 2:00 p.m., 4:00	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 42 p.m., 9:00 p.m. R1's record included handouts authenticated by renal dietitian, Meeting Fluid Goals Can Improve Quality of Life/ Basic Diet for People on Dialysis, dated December 23, 2022, that included: -fluid goal= 32 ounces/day -basic diet for people of dialysis -food I can enjoy -high potassium foods/limit. R1's record did not include evidence of an individualized treatment management plan for R1's specialized diet or carb counting which included: - a written statement on the service plan of the treatment or therapy services that will be provided to the resident; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatment or therapy services. On September 26, 2023, at 10:33 a.m., CNS-D stated R1's record "should" contain a statement of when to notify registered nurse (RN) in regard to R1's specialized diet. CNS-D confirmed R1's record did not include when to notify nursing in regards to carb counting. On September 26, 2023, at approximately 2:50 p.m., LALD/O-A stated he was not aware specialized diets were considered treatments. LALD/O-A confirmed R1's treatment and therapy management plan for specialized diet was incomplete as it did not include the above noted required content. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, noted the facility would develop and maintain a	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 43 current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that would be provided -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that would be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatment or therapy services -any resident specific requirement relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 44 professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022, indicated the resident received services which included: -monitoring blood glucose three (3) times per day	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 45 -meal assistance three (3) times per day. BLOOD GLUCOSE MONITORING R1's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -FreeStyle Libre 2 (measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm) four (4) times daily (before meals and nightly.) R1's medication administration record (MAR) dated May 1, 2023, through May 20, 2023, included: -insulin Aspart 100 units/milliliter (ml) 1-7 units three (3) times daily (before meals) correction do not give correction insulin if pre-meal blood glucose (BG) less than 140. For pre-meal BG 140-189 give 1 unit. For pre-meal BG 190-239 give 2 units, for pre-meal BG 240-289 give 3 units, for pre-meal BG 290-339 give 4 units, for pre-meal BG 340-399 give 5 units, for pre-meal BG 400-449 give 6 units, for pre-meal BG greater than or equal to 450 give 7 units. To be given with prandial insulin (coverage increased in BG levels following meals) and based on pre-meal blood glucose. Notify provider if glucose greater than or equal to 350 mg/dl (deciliter/ unit of measurement) after administration of correction dose: 7:00 a.m., 12:00 p.m., 7:00 p.m. -insulin Aspart 100 units/ ml 1-5 units at bedtime. Do not give if BG less than 200, for BG 200-249 give one (1) unit, for BG 250-299 give two (2) units, for BG 300-349 give three (3) units, for BG 350-399 give four (4) units, for BG greater than or equal to 400 units give five (5) units. Notify provider if glucose greater than or equal to 350 mg/dl after administration of correction dose: 11:00 p.m. R1's Record-Blood Glucose-task sheet dated	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 46 active on December 21, 2022, included: -wearing gloves and following agency procedure, check blood glucose, and record -notify RN (registered nurse) if BG is less than 70 or greater than 300 -refer to sliding scale insulin. On September 26, 2023, at 10:43 a.m., clinical nurse supervisor (CNS)-D stated sometimes "we" (facility) poked R1's fingers when the Libre BG system read "HI," (high) (used lancet/small needle used to poke the skin [usually on a finger] to get a small drop of blood. The blood sample is put onto a BS testing strip which had been inserted into the BS meter). CNS-D stated R1 wore a Libre BG monitor but "we" (facility) also did the finger pricks. CNS-D added she was not sure why R1's meter read "HI." CNS-D was unable to review R1's record at the time of the interview but added, staff know when to call "me" and stated staff were trained on using both types of BG meters. CNS-D was not able to state where in R1's record instructions were for unlicensed personnel (ULPs) to follow regarding which BG system to use and when. DIET/FLUID RESTRICTION R1's most current assessment dated April 27, 2023, and included: -Nutritional/hydration status: regular and diabetic diet (inconstancy vegetables, fewer added sugars and refined grains, whole foods, lean meats), eats three (3) meals a day and sometimes snacks depending on sugar levels -Hydration status: fluid restriction -current fluid intake pattern: stated takes most times 32 ounces a day due to kidney failure and fluid restriction. R1's after visit summary, electronically signed by	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 47 a prescriber, dated May 19, 2023, included: -Combination diet renal diet (dialysis); two (2) gram NA (sodium) diet. R1's Record-Meal Assistance-task sheet dated active on December 21, 2022, included: -provide any needed assistance at mealtime (specify): Resident is on a low sodium diet aimed at reducing sodium intake due to kidney disease. When preparing and serving the residents meals, limit high-sodium foods like processed foods, salty snacks, canned goods, and certain seasoning. Serve fresh fruits, vegetables, whole grains, lean proteins, and carefully portioned low-sodium alternatives. R1's record included handouts authenticated by renal dietitian, Meeting Fluid Goals Can Improve Quality of Life/ Basic Diet for People on Dialysis, dated December 23, 2022, that included: -fluid goal= 32 ounces/day -basic diet for people of dialysis -food I can enjoy -high potassium foods/limit. On September 26, 2023, at 10:05 a.m., CNS-D was asked where in R1's record could direction for staff to follow for fluid restrictions be found. CNS-D stated it was "confusing, sometimes she (R1) was on it (restrictions) and other times not. CNS-D added "to be honest with you, she (R1) did not drink much." On September 28, 2023, at 11:10 a.m., R1's "Rtask" (on-line system) service task sheets for BG monitoring and meal assistance were reviewed with licensed assisted living director/owner (LALD/O)-A. LALD/O-A confirmed specific instructions for ULPs to follow for BG and meal assistance were not found in R1's record.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01950	Continued From page 48 On September 28, 2023, at 1:18 p.m., CNS-D stated R1 was on fluid restrictions and a renal dietitian provided education tips and documents to review with staff. CNS-D added the handout was reviewed during a meeting held on February 4, 2023. In addition, CNS-D said R1's diabetic diet was a renal diet. CNS-D did not state where in R1's record directions for staff to follow regarding R1's fluid restriction or when to report to nursing would be found. The licensee's Medication & Treatment-Administration Delegation policy dated August 1, 2021, noted when administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the facility would ensure the registered nurse had: -instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 49 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of one resident (R1) with health monitoring managed by the provider. 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's diagnoses included diabetes, high blood pressure (HTN), ESRD (end-stage renal disease/medical condition in which kidneys cease functioning leading to dialysis/treatment to clean blood), neuropathy (nerve damage/pain, tingling, numbness), and chronic pain. R1's service plan dated December 22, 2022,	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 50 indicated the resident received services which included: -monitoring blood glucose three (3) times. R1's after visit summary, electronically signed by prescriber, dated May 19, 2023, included: -FreeStyle Libre 2 (measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm) four (4) times daily (before meals and nightly.) R1's medication administration record (MAR) dated May 1, 2023, through May 20, 2023, included: -insulin Aspart 100 units/ ml 1-7 units three (3) times daily (before meals) correction do not give correction insulin if pre-meal blood glucose (BG) less than 140. For pre-meal BG 140-189 give one (1) unit. For pre-meal BG 190-239 give two (2) units, for pre-meal BG 240-289 give three (3) units, for pre-meal BG 290-339 give four (4) units, for pre-meal 340-399 give five (5) units, for pre-meal 400-449 give six (6) units, for pre-meal BG greater than or equal to 450 give seven (7) units. To be given with prandial insulin (coverage increased in BG levels following meals) and based on pre-meal blood glucose. Notify provider if glucose greater than or equal to 350 mg/dl (unit of measurement) after administration of correction dose: 7:00 a.m., 12:00 p.m., 7:00 p.m. -insulin Aspart 100 units/ ml 1-5 units at bedtime. Do not give if BG less than 200, for BG 200-249 give one (1) unit, for BG 250-299 give two (2) units, for BG 300-349 give three (3) units, for BG 350-399 give four (4) units, for BG greater than or equal to 400 units give five (5) units. Notify provider if glucose greater than or equal to 350 mg/dl after administration of correction dose: 11:00 p.m.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 51 R1's Record-Blood Glucose-task sheet dated active on December 21, 2022, included: -notify RN (registered nurse) if BG is less than 70 or greater than 300. R1's vital signs tracking form dated April 1, 2023, to May 20, 2023, included: BG reading -April 1, 2023, 487 -April 7, 2023, 527 -April 8, 2023, 363 -April 9, 2023, 376 -April 11, 2023, 349 -April 12, 2023, 349 -April 15, 2023, 331 -April 16, 2023, 333 -April 19, 2023, 304 -April 27, 2023, 323 and 380 -April 29, 2023, 307 -May 3, 2023, 303, 400, and 395 -May 4, 2023, 360 -May 6, 2023, 348 -May 8, 352, and 318 -May 9, 2023, 342 -May 12, 2023, 354 -May 14, 2023, 58 1 of 22 opportunities documentation of RN notification had been completed when BGs were out of range on the tracking form/vital sign form. R1 Resident Notes dated April 1, 2023, to May 12, 2023, included documentation: -April 9, 2023, BG low, gave glucose tablet, rechecked 63, RN updated. On April 26, 2023, at 10:47 a.m., clinical nurse supervisor (CNS)-D stated staff knew when to call her, adding she was concerned when R1's BG was "HI" (high). CNS-D was unable to review documentation at the time of interview to state if BG notification documentation was in R1's record	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 52 or not. On April 26, 2023, at 11:51 a.m., R1's BG reporting was reviewed with licensed assisted living director/owner (LALD/O)-A stated, "it (documentation) just happened one (1) day," LALD/O-A added staff had reported low readings but not high readings. The licensee's Medication & Treatment-Administration Delegation policy dated August 1, 2021, noted when administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the facility would ensure the registered nurse had: -instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures -communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 53 Based on observation and interview, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for six of six oxygen tanks. 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 September 25, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. The surveyor observed two (2) tall oxygen tanks unsecured in the living room/common's area of the facility. In addition, the surveyor observed two (2) small oxygen tanks unsecured, and two (2) medium oxygen tanks unsecured in a bedroom which was connected to the kitchen on the main floor of the facility. There was one (1) oxygen roller cart empty positioned near the oxygen tanks in the bedroom. On September 25, 2023, at 11:26 a.m., LALD/O-A stated all the oxygen tanks belonged to R1 and R1's family said they would pick up the oxygen tanks. LALD/O-A added that (pick up) had not happened yet and "they" (facility) would have to contact the oxygen company. LALD/O-A said he was not sure if they oxygen tanks needed to be secured, "that is a nursing thing."	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39371	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER METRO ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2307 ERICON DRIVE BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 54 On September 25, 2023, at 11:41 a.m., clinical nurse supervisor (CNS)-D stated R1's oxygen tanks should be secured. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. The licensee's Oxygen policy dated August 1, 2021, noted never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			

Type: Full
Date: 09/26/23
Time: 15:00:00
Report: 8087231276

Food and Beverage Establishment Inspection Report

Page 1

Location:

Metro Assisted Living
2307 Ericon Drive
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0042089
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air

Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Air

Temperature: 6 Degrees Fahrenheit - Location: FREEZER

Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IN 2-BIN, RESIDENTIAL KITCHEN SINK.

FACILITY IS CURRENTLY VACANT WITH NO RESIDENTS CURRENTLY LIVING THERE.

INSPECTION REPORT EMAILED TO CYNDI CASEY (HRD NURSE EVALUATOR).

Type: Full
Date: 09/26/23
Time: 15:00:00
Report: 8087231276
Metro Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087231276 of 09/26/23.

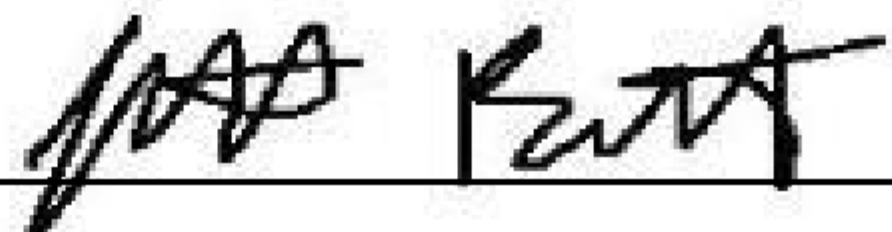
Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative
OWNERSHIP TEAM

Signed:  _____

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