



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2025

Licensee

Aspen Grove Alternative Senior Living

511 Iron Drive

Chisholm, MN 55719

RE: Project Number(s) SL37901016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEphVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37901	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37901016 On March 3, 2025, through March 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 28 residents receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license, effective August 1, 2024. The licensee's renewal Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally	0 420			

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0 420	Continued From page 2 responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on May 2, 2024. As a result of this survey, the following orders were issued under 0470, 0480, 0510, 0650, 0660, 0680, 0775, 0810, 1290, 1420, 1440, 1500, 1620, 1640, 1750, 1760, 1880, 1950, 1960, 2040, 2070, 2160, 2170, 2310, 2370, and 2430, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required	0 470			

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0 470	Continued From page 3 by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a staffing plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents. 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:	0 470			

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0 470	Continued From page 4 The licensee held an assisted living dementia care license. The facility was licensed for a capacity of 30 residents and had a current census of 28 residents. On March 3, 2025, at 9:31 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all 28 residents received services. On March 3, 2025, at 9:50 a.m., LALD/CNS-A stated the usual staffing schedule for the facility was as follows: - day shift was staffed with two unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m. - afternoon shift was staffed with two ULP from 3:00 p.m. to 11:00 p.m. - night shift was staffed with one ULP from 11:00 p.m. to 7:00 a.m. On March 3, 2025, at 12:30 p.m., the surveyor reviewed the licensee's staffing plans with registered nurse (RN)-C. RN-C stated there was no metric to indicate how the licensee determined the facility's staffing needs. The surveyor reviewed the staffing plans dated January 2025, and July 2024, respectively. The staffing plans noted: RNs/ CNS will evaluate prospective and current clients to ensure that each house is adequately staffed according to client needs a. all numbers and staffing times are based on resident needs and roster b. all staff members are to call LALD/CNS-A, director maintenance (DM)-D, unidentified RN, or RN-C if they need help with a resident. Staffed as follows: - dayshift: two staff members i. main staff: 7:00 a.m. -3:00 p.m.	0 470			

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0 470	Continued From page 5 ii. float staff: 7:00 a.m. -3:00 p.m./ 8:00 a.m. -3:00 p.m. - afternoons: two staff members i. main staff: 3:00 p.m. - 11:00 p.m. ii. float staff: 3:00 pm. - 8:00 p.m. - midnights: one staff member i. main staff: 11:00 p.m.- 7::00 a.m. CNS will review the schedule every six months and as needed according to client (resident) needs. On March 3, 2025, at 1:51 p.m., LALD/CNS-A stated the staffing needed "never" changed. LALD/CNS-A stated when residents were admitted criteria was used to determine if a resident was admitted to the facility. The surveyor asked LALD/CNS-A what if a resident's health/ needs were to change? On March 4, 2025, at 6:02 a.m., the surveyor observed ULP-F enter R4's room. ULP-F gently attempted to wake R4. ULP-F stated it was R4's shower day. ULP-F stated if it was not R4's shower day he would let her (R4) sleep in. ULP-F stated, he could not make "it up" (shower scheduled on night shift), and added R4 was "about 90 years old." ULP-F stated there was a night when two showers were scheduled. On March 4, 2025, at 6:20 a.m., ULP-F attempted to shower R4. ULP-F dressed R4 and assisted R4 out of the shower room. Once outside of the shower room, R4 put herself on the floor. ULP-B had come into work earlier than scheduled and assisted ULP-F to get R4 to a standing position and back to R4's room. On March 4, 2025, at 6:52 a.m., ULP-F assisted an unidentified resident who had leaned over on a couch in the common's area. ULP-F stated that	0 470			

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0 470	Continued From page 6 resident had been "across the street" (at another facility owned/operated by the licensee). ULP-F stated the unidentified resident used to talk at the other facility, but ULP-F was not sure if the unidentified resident ever spoke while at "this" facility. On March 4, 2025, at 7:14 a.m., ULP-B stated ULP-G would be at the facility at 8:00 a.m., to start the shift, not at 7:00 a.m. ULP-B confirmed she was the only ULP on site at the facility until 8:00 a.m. On March 4, 2025, at 9:10 a.m., LALD/CNS-A stated sometimes ULPs worked 12 hours if someone wanted extra hours. LALD/CNS-A confirmed one day a week, normally, there was only one staff in the facility from 7:00 a.m., until 8:00 a.m., as one ULP had daycare issues. On March 5, 2025, at 12:23 p.m., RN-C confirmed the licensee's staffing plan did not include required information. The licensee's Staffing and Scheduling policy dated August 30, 2021, noted the clinical nurse supervisor would develop and implemented that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels were adequate to address the following: - each resident's needs, as identified in the resident's service plan and assisted living contract - each resident's acuity level, as determined by the most recent assessment or individualized review -the ability of staff to timely meet the resident's	0 470			

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0 470	Continued From page 7 scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises - where the facility had a secured dementia care unit, and - staffs experience, training, and competency. The clinical nurse supervisor would develop a 24-hour daily staffing schedule that would identify: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and -the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	0 480			

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0 480	Continued From page 8 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480			

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0 480	Continued From page 9 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510			

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0 510	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel (ULP-B) during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 3, 2025, at 2:10 p.m., the surveyor observed ULP-B apply hand sanitizer and review R3's MAR. ULP-B removed half of a 20 mg furosemide tablet (10 mg) from a bubble pack and placed the tablet into a medication cup. ULP-B filled a glass with water and took the medication cup and water to R3 who was ambulating in the hallway. ULP-B told R3, " I have one little pill for you." The furosemide tablet dropped onto the floor. ULP-B located the tablet on the floor near R3. ULP-B picked the tablet up off the floor, looked at the tablet, and wiped the tablet off with ULP-B's hand. ULP-B handed the tablet to R3 and the glass of water. R3 swallowed the furosemide tablet. ULP-B returned to the medication room to document R3's medication administration. On March 3, 2025, at 2:46 p.m., licensed assisted	0 510			

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0 510	Continued From page 11 living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B should have contacted her, and she (LALD/CNS-A) would have contacted the pharmacy to replace the tablet that had dropped onto the floor. LALD/CNS-A stated a new tablet should have been administered to R3. LALD/CNS-A stated, "I don't care if the pill was wet or dry, that should not have happened" (medication given after dropped on the floor). On March 4, 2025, at 7:19 a.m., ULP-B stated, "right after I gave it (R3's furosemide tablet), I thought, what am I doing." ULP-B stated it would be like picking food up off the floor. ULP-B stated the procedure was to contact "my boss" to get a replacement furosemide. ULP-B stated R3's furosemide tablet was contaminated. The licensee's infection control policy dated August 30, 2021, noted the licensee's infection control program would be consistent with current guidelines form CDC (Center for Disease Control) for prevention control in long-term care facilities, where applicable in assisted living facilities. The licensee's Medication Loss or Spillage policy dated August 30, 2021, noted when a loss or spillage of a medications, including schedule II medications, occurs a notation must be made in the resident's record expanding the spillage and the actions taken. The notation must be signed by the person responsible for the loss or spillage and include verification that any contaminated substance was disposed of according to state and federal regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510			

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NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719		
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0 510	Continued From page 12 days	0 510			
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, registered nurse (RN)-C). This practice resulted in a level two violation (a	0 650			

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0 650	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 3, 2025, at 9:41 a.m., LALD/CNS-A stated she was aware of the required content of employee records. LALD/CNS-A LALD/CNS-A was hired in April 2013, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On March 3, 2025, at 12:39 p.m., the surveyor observed LALD/CNS-A review R8's morning medication per unlicensed personnel (ULP)-B's request. LALD/CNS-A's employee record did not include: -a review of the Minnesota Assisted Living Bill of Rights. RN-C RN-C was hired in June 2017, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On March 3, 2025, at 9:28 a.m., during the entrance conference RN-C was identified as a full time RN at the facility who worked Monday	0 650			

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0 650	Continued From page 14 through Friday 9:00 a.m. until 5:00 p.m. RN-C's employee record did not include: -a review of the Minnesota Assisted Living Bill of Rights. On March 5, 2025, at 10:56 a.m., RN-C stated LALD/CNS-A and herself (RN-C) had reviewed the assisted living bill of rights however there was no evidence of this in either of their employee records. The licensee's Employee Records policy dated August 30, 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 -verification of completed orientation and annual training and competency testing as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, 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	0 650			

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0 650	Continued From page 15 instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (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 maintain a tuberculosis (TB)	0 660			

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0 660	Continued From page 16 prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by not completing a TB risk assessment annually. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on March 3, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility risk assessment had been completed on March 3, 2025, and the TB risk assessment indicated the facility was at a low risk level. On March 3, 2025, at 10:45 a.m., the facility TB risk assessment was reviewed by the surveyor. The TB risk assessment was dated. May 23, 2023. On March 3, 2025, at 11:18 a.m., the surveyor reviewed the facility's TB risk assessment with registered nurse (RN)-C. RN-C stated the most current TB risk assessment was in the binder the surveyor reviewed. RN-C stated she was aware of the requirement for annual TB risk assessments. RN-C stated she could remember dates of birth and other things, but she forgot to update the TB risk assessment. LALD/CNS-A reviewed the licensee's policy and the TB	0 660			

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0 660	Continued From page 17 guidelines for TB risk assessment requirements with the surveyor. LALD/CNS-A took a photo of the licensee's TB policy for future reference. The licensee's undated Tuberculosis control program policy noted low risk setting to update assessment every year. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to 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	0 680			

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0 680	Continued From page 18 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) with all the required content and failed to post an EPP prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 3, 2025, at 9:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility's EPP was located in the locked office. On March 3, 2025, at 10:01 a.m., during a tour of the facility with registered nurse (RN)-C, the surveyor did not observe any signage of the	0 680			

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0 680	Continued From page 19 facility's EPP. RN-C stated there was no signage on the unit to indicate where the facility's EPP was located. The facility's review of EPP was dated August 2024. On March 3, 2025, at 1:16 p.m., the surveyor asked LALD/CNS-A to review the facility's EPP. LALD/CNS-A stated she needed to get other pieces of the EPP she had updated, that were not in the EPP. On March 3, 2025, at 1:34 p.m., the EPP binder was reviewed with LALD/CNS-A. The EPP lacked the following content and/or policies and procedures to address: - a description of the population served by the licensee - tracking of on duty staff and residents - use of volunteers - missing person policy reviewed quarterly - process for cooperation and collaboration with local, tribal, regional, state and federal EP - communication plan to include resident's physicians, and other facilities - contact information for Minnesota Office of Ombudsman for long term care. On March 3, 2025, at 1:48 p.m., LALD/CNS-A confirmed the EPP was not posted prominently, and that the facility's EPP lacked required content. The licensee's Missing Resident policy dated August 30, 2021, noted the licensee would review the missing person policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented.	0 680			

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0 680	Continued From page 20 The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 30, 2021, noted the licensee would have an emergency preparedness plan that included all required elements of appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775			

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0 775	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 5, 2025, from 9:45 a.m. to 11:10 p.m., with director of maintenance (DM)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: FIRE ALARM SYSTEM There was no documentation provided the building fire alarms system was serviced and tested as required. The building fire alarm system is required to be serviced and tested annually and any noted deficiencies during the testing corrected. During the tour DM-D, stated they thought the contractor/ vendor would initiate the required service, but they did not. EMERGENCY LIGHTING MAINTENANCE	0 775			

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0 775	Continued From page 22 The emergency light fixtures with the larger double lights installed throughout the facility did not operate as required when the test buttons were activated. All fire safety equipment including emergency lighting installed within the building is required to be maintained in working condition as designed and installed at the time of construction approval. COMMERCIAL KITCHEN HOOD DUCT AND FAN CLEANING There was not documentation indicating the commercial kitchen hood and duct system were cleaned as required. BREATHING OXYGEN USE There was an oxygen machine and spare tank located in the resident room occupied by R7, with no sign at the entry door to the room indicating oxygen in use. Entrance doors of rooms containing the use of oxygen are required to be marked with a sign indicating oxygen is in use in the room or space. During the facility tour DM-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

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0 810	Continued From page 23 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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0 810	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 5, 2025, at 9:05 a.m., licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and registered nurse (RN)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The location and number of resident sleeping rooms were not identified on the posted FSEP evacuation floor plan. It was explained to LALD-A, DM-D, and RN-C, that resident sleeping room numbers are required to be included on the evacuation floor plan. The room numbers are required in order to direct building occupants to an exit and identify the location of specific resident rooms for occupants and responders in the event of a fire or similar emergency. During a facility tour on March 5, 2025, from 9:45 a.m. to 11:10 p.m., with director of maintenance (DM)-D, it was observed resident room numbers were not installed on the resident room doors to	0 810			

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0 810	Continued From page 25 match the evacuation floor plan map. Resident room numbers are required to be installed on doors in order to identify the location of the resident rooms for direction in the event of a fire or similar emergency. The available FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include specific and detailed actions for employees to take in this facility in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on March 5, 2025, at 9:15 a.m., LALD-A, stated the FSEP evacuation map did not include location and numbers of resident rooms, and procedures for employees and residents to take in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the training was completed one time per year and not twice. During an interview on March 5, 2025, at 9:25 a.m., LALD-A, and RN-C, stated documentation was available that employees were trained once annually on the FSEP but not twice.	0 810			

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0 810	Continued From page 26 DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed February, May, August, and November of 2024 only. No further information was provided. During an interview on March 5, 2025, at 9:25 a.m., LALD-A, stated evacuation drill documentation was available for February, May, August and November of 2024 only. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil	01290			

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01290	Continued From page 27 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 37901) for one of one employee (unlicensed personnel (ULP)-F). This had the potential to affect all 28 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 3, 2025, at 9:50 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the usual staffing schedule for the facility was as follows: - the night shift was staffed with one ULP from 11:00 p.m. to 7:00 a.m. ULP-F was hired on April 26, 2024, to provide direct care services to the licensee's residents. On March 4, 2025, at 6:20 a.m., the surveyor observed ULP-F give R4 a shower. ULP-F stated he was the only employee working at the facility	01290			

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01290	Continued From page 28 at that time, night shift. ULP-F stated he worked at this facility and at the other facility (owned by the licensee) "across the street." ULP-F's record included a background study dated March 3, 2025, for HFID 30680, (a sister facility). ULP-F's record lacked documentation of a cleared background study affiliated with the facility's correct HFID. On March 5, 2025, at 10:41 a.m., registered nurse (RN)-C stated the licensee did not know they (licensee) needed to "hit" the affiliated key when submitting background studies. RN-C stated background studies not affiliated with the correct HFID number was a widespread issue. The licensee's Background Studies policy dated August 30, 2021, noted: -using the Minnesota Department of Health Services NETStudy online program, the licensee would initiate a background study on all employees being considered for hire - if hired prior to receiving the results of the background study, or the tentative background study results indicated more time was needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients (residents) of the licensee except under the direct supervision (eyesight) of another qualified staff person. - once an approved background study had been received, staff may act independently with residents, assuming all other requirements had been met - copies of completed background studies shall be kept in the individual employee records.	01290			

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01290	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide complete written instructions in the resident record for delegated tasks for one of one resident (R8) for indwelling catheter care (suprapubic/ device that drains urine from the bladder through belly button or abdomen). 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	01420			

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01420	Continued From page 30 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: R8's diagnoses included benign prostatic hyperplasia (BPH/ noncancerous enlargement of the prostate gland causing difficulty urinating). R8's service plan dated May 10, 2023, indicated R8 received "cath" (catheter) care daily. On March 4, 2025, at 10:25 a.m., the surveyor observed ULP-G check R8's leg bag (urine containment system). R8 stated he had just emptied the leg bag. ULP-G wet a washcloth and applied cleaner to the washcloth. With gloved hands ULP-G cleaned around the catheter (suprapubic/ device that drains urine from the bladder through belly button or abdomen) entry site with the moistened washcloth. ULP-G wet a clean washcloth and cleaned around the site, to rinse the area. R8's assessment dated February 3, 2025, included: - Foley cath (device that drains urine from your bladder, via a tube inserted into urethra) care, daily, full assist. R8's treatment record dated March 1, 2025, through March 4, 2025, noted: -daily catheter care around insertion site. R8's record did not include necessary instructions, to include the type of cath and when and what to report to nursing.	01420			

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01420	Continued From page 31 On March 5, 2025, at 10:25 a.m., registered nurse (RN)-C stated she taught staff to report signs and symptoms of infection, such as change in odor, change in urine, swelling, if the tubing looked different, "was a different length," and if there was any pain. RN-C stated when records were recently printed out some items got omitted. RN-C stated she was not aware R8's record no longer included what/ when to report to nursing regarding R8's catheter. On March 5, 2025, at 11:45 a.m., R8's record was reviewed with RN-C. RN-C stated R8 use to have a Foley catheter however R8 currently had a suprapubic catheter in place. RN-C stated R8's record did not include required information. The licensee's roster was reviewed with RN-C. RN-C stated R8 was the only resident that received a delegated task at the current time. The licensee's Delegation of Assisted Living services dated August 1, 2021, noted the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440			

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01440	Continued From page 32 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01440			

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01440	Continued From page 33 The findings include: ULP-F was hired on April 26, 2024, to provide direct care services to the licensee's residents. On March 4, 2025, at 6:20 a.m., the surveyor observed ULP-F give R4 a shower. ULP-F stated he had given one medication during night shift, a PRN (as desired or as needed) medication to R6. ULP-F's record included: -PCA (personal care assistance/ULP) supervisory note dated April 26, 2024 -performance evaluation dated June 2, 2024, which did not include observation of delegated tasks. On March 5, 2025, at 10:39 a.m., the surveyor reviewed ULP-F's record with registered nurse (RN)-C. RN-C confirmed the supervisory note dated April 26, 2024, was not done within 30 days after ULP-F began performing delegated tasks for the licensee. RN-C stated ULP-F's record lacked evidence a 30 supervisor was completed as required The licensee's Supervision of Staff- Delegated Services policy dated August 30, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			

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01500	Continued From page 34	01500			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 35 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for two of three employees (licensed assisted living director/ clinical nurse supervisor (LALD/CNS-A, registered nurse (RN)-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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01500			

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01500	Continued From page 36 The findings include: LALD/CNS-A LALD/CNS-A was hired in April 2013, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On March 3, 2025, at 12:39 p.m., the surveyor observed LALD/CNS-A review R8's morning medication per unlicensed personnel (ULP)-B's request. LALD/CNS-A's employee record lacked evidence CNS-C successfully completed annual training as required to include: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - training on reporting of maltreatment of vulnerable adults (VA) - review of infection control techniques - a minimum of eight hours of training per 12 months of employment. RN-C RN-C was hired in June 2017, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On March 3, 2025, at 9:28 a.m., during the entrance conference, RN-C was identified as the full time RN at the facility who worked Monday through Friday 9:00 a.m. until 5:00 p.m. RN-C's employee record lacked evidence RN-C successfully completed annual training as required to include: - the principles of person-centered planning and service delivery and how they apply to direct	01500			

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01500	Continued From page 37 support services provided by the staff person - training on reporting of maltreatment of VA - review of infection control techniques - a minimum of eight hours of training per 12 months of employment. On March 5, 2025, at 10:54 a.m., LALD/CNS-A's employee file was reviewed with RN-C. RN-C confirmed LALD/CNS-A had not completed person centered planning and service delivery, a review of infection control, and training on reporting maltreatment of VA as required. RN-C confirmed LALD/CNS-A had not completed eight hours of annual training. RN-C stated her (RN-C) employee file was the same and lack required annual training. On March 5, 2025, at 10:57 a.m., RN-C stated she was focused on staff's required training and not the nurses required training. The licensee's Annual Required Staff Training policy dated August 30, 2021, noted all staff that perform direct care services will complete at least eight hours of annual training for each 12 months of employment. The following training elements must be included every 12 months to all staff who performed direct care services: - training on reporting of maltreatment of vulnerable adults under section 626.557 - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and the use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases.	01500			

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01500	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change of	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 39 condition assessment for one of three residents, (R8). 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. During the entrance conference on March 3, 2025, at 9:40 a.m., with licensed assisted living director/clinical nurse supervisor) and registered nurse (RN)-C, RN-C stated the licensee currently had one suprapubic catheter at the facility. R8's diagnoses included benign prostatic hyperplasia (BPH/ noncancerous enlargement of the prostate gland causing difficulty urinating). R8's service plan dated May 10, 2023, indicated R8 received "cath" (catheter) care daily. On March 4, 2025, at 10:25 a.m., the surveyor observed ULP-G check R8's leg bag (urine containment system). R8 stated he had just emptied the leg bag. ULP-G wet a washcloth and applied cleaner to the washcloth. With gloved hands ULP-G cleaned around the catheter (suprapubic/ device that drains urine from the bladder through belly button or abdomen) entry site with the moistened washcloth. ULP-G wet a clean washcloth and cleaned around the site, to rinse the area.	01620			

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01620	Continued From page 40 R8's assessment dated May 9, 2024, and February 3, 2025, respectively included: - Foley cath (device that drains urine from your bladder, via a tube inserted into urethra) care, daily, full assist. R8's treatment record dated March 1, 2025, through March 4, 2025, noted: -daily catheter care around insertion site. R8's record did not include an updated assessment to include the current type of catheter. On March 5, 2025, at 11:45 a.m., R8's record was reviewed with RN-C. RN-C stated R8 use to have a Foley catheter however R8 currently had a suprapubic catheter in place. RN-C confirmed R8's assessment stated Foley catheter not suprapubic catheter, and the assessment was not updated. The licensee's Assessments, Reviews, and Monitoring policy dated June 2021, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640			

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01640	Continued From page 41 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 observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for two of four residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01640			

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01640	Continued From page 42 R3 R3's diagnoses included hypertension (HTN/high blood pressure), mood disorder, and Alzheimer's dementia. R3's service plan dated November 18, 2023, included low sodium diet. On March 3, 2025, at 11:42 a.m., the surveyor observed unlicensed personnel (ULP)-B ask R3 to go to the dining area for lunch, and at 2:10 p.m., the surveyor observed ULP-B administer medication to R3. R3's prescriber order dated November 15, 2024, included regular diet. R3's service plan had not been revised as required. R3 no longer received a low sodium diet. On March 5, 2025, at 11:30 a.m., registered nurse (RN)-C stated R3's service plan was not updated as required, and the low sodium diet service should have been removed as R3's prescriber changed R3's diet. R4 R4's diagnoses included dementia, diabetes, and major depressive disorder. R4's service plan dated September 16, 2021, indicated R4 received the following services: - Accu-Chek (blood glucose) monitoring daily - medication administration twice daily and as needed (PRN). On March 4, 2025, at 6:20 a.m., ULP-F attempted to shower R4. ULP-F dressed R4 and assisted	01640			

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01640	Continued From page 43 R4 out of the shower room. R4's medication administration record (MAR) dated March 1, 2025, through March 4, 2025, included: - Accu-Chek twice daily, 7:00 a.m., 7:00 p.m. - Tylenol (mild pain) 500 milligrams (mg), one tablet three times daily: 8:00 a.m., 2:00 p.m., 8:00 p.m. R4's prescriber order dated March 21, 2024, included the above orders. On March 4, 2025, at 1:17 p.m., RN-C stated R4's service plan had not been revised as required to include R4's change in service: increased Accu-Chek frequency and increased medication administration. The licensee's Service Plan Modifications policy dated August 30, 2021, noted when a resident at the facility received assisted living services and a change (s) to the service plan occurred, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01750 SS=E	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	01750			

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01750	Continued From page 44 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for three of five residents (R5, R6, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5's diagnoses included Alzheimer's dementia, allergies, depression, hypertension (HTN/high blood pressure), and gastroesophageal reflux disease (GERD/ stomach acid that repeatedly flows back up into the esophagus). R5's service plan dated August 31, 2023, indicated R5 received medication administration twice daily and as needed (PRN).	01750			

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01750	Continued From page 45 On March 4, 2025, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-B administer a glass of Metamucil (bowel health) and hand a container of Flonase nasal spray (allergies) to R5. R5's medication administration record (MAR) dated March 1, 2025, through March 4, 2025, included: - alendronate 70 milligrams (mg) (Fosamax), one tablet by mouth weekly on Monday, bone health, 8:00 a.m. R5's MAR dated March 1, 2025, through March 4, 2025, 8:00 a.m., also included: -Flonase 50 micrograms (mcg), two sprays to both nostrils, daily, - Protonix 40 mg, (GERD) - Zoloft 25 mg, (depression) - multivitamin, (supplement) - Metamucil, one packet, drink as directed, (bowel health) - Lasix 20 mg, (HTN) - aspirin 81 mg, (heart health) - calcium/ vitamin D 600 mg/5 mcg, (supplement) - clopidogrel 75 mg (anticoagulant). R5's prescriber order dated April 30, 2024, included the above orders. R5's record did not include specific resident instructions for administration of alendronate. The manufacturer's instructions for alendronate dated 2000, noted: - do not eat, drink, or take other medicines or supplements before taking alendronate - wait for at least 30 minutes after taking alendronate to eat, drink, or take other medicines	01750			

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01750	Continued From page 46 or supplements - do not lie down for at least 30 minutes after taking alendronate. Do not lie down until after your first food of the day. On March 5, 2025, at 12:01 p.m., R6's MAR was reviewed with registered nurse (RN)-C and alendronate manufacturer's instructions. RN-C stated she was not aware of alendronate's manufacturer's administration instructions. RN-C confirmed R5's record did not include manufacturer's instructions for alendronate administration. R6 R6's diagnoses included diabetes, mood disorder, and post-traumatic stress disorder (PTSD/flash backs, nightmares, severe anxiety.) R6's service plan dated November 28, 2023, indicated R6 received medication administration four times daily and PRN. R6's MAR dated March 1, 2025, through March 4, 2025, included: -Novolog 100 units/milliliter (ml) (short acting insulin), ten units subcutaneous (SQ/under skin into fatty tissue) before breakfast -Novolog 100 units/ml, ten units SQ before lunch -Novolog 100 units/ml, eight units SQ before supper R6's prescriber order dated January 3, 2025, included the above orders. On March 4, 2025, at 8:12 a.m., the surveyor observed ULP-G use correct technique to administer ten units of Novolog insulin into R6's lower left abdomen.	01750			

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01750	Continued From page 47 Directly after the above observation the surveyor and ULP-G reviewed R6's MAR. ULP-G stated there was no place to document insulin injection sites in R6's MAR. ULP-G stated she used a different injection site for the noon Novolog administration. R6's record did not include specific resident instructions for administration of Novolog insulin, to include injection site. The manufacturer's instructions for Novolog dated January 2019, noted rotate injections between injection spots, do not inject into the same spot every time. On March 4, 2025, at 9:16 a.m., the surveyor reviewed manufacturer's instructions for Novolog insulin administration with RN-C. RN-C stated she had never thought about "that" (rotating injection sites/including information in MARs). RN-C confirmed R6's MAR did not include specific instructions for Novolog administration. R4 R4's diagnosis included diabetes and dementia. R4's service plan dated September 16, 2021, indicated R4 received medication administration twice daily, and PRN and SQ insulin every HS (hour of sleep). R4's MAR dated March 1, 2025, through March 4, 2025, included: -Lantus 100 units/ml, (long-acting insulin)10 units every evening 7:00 p.m. R4's prescriber order dated November 1, 2024, included the above order.	01750			

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01750	Continued From page 48 On March 4, 2025, at 6:20 a.m., ULP-F attempted to shower R4. R6's record did not include specific resident instructions for administration of Lantus insulin, to include injection site. The manufacturer's instructions for Lantus dated August 2022, noted change (rotate) your injection sites within the area you choose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection site. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. On March 4, 2025, at 1:20 p.m., R4's record was reviewed with RN-C. RN-C stated R6's MAR did not include instructions to rotate, and to document R4's Lantus injection sites as required. The licensee's Medication & Treatment-Administration & Delegation policy dated August 30, 2021, noted when administration of medications was delegated or assigned to unlicensed personnel, the licensee would ensure that the RN had: - specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760			

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01760	Continued From page 49 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-B followed registered nurse (RN) written instructions for one of three residents (R5). In addition, the licensee failed to ensure manufacturer's instructions were followed for one of three residents, (R8) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01760			

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01760	Continued From page 50 WRITTEN INSTRUCTIONS R5 R5's diagnoses included Alzheimer's dementia and allergies. R5's service plan dated August 31, 2023, indicated R5 received medication administration twice daily and as needed (PRN). R5's medication administration record (MAR) dated March 1, 2025, through March 4, 2025, included: -Flonase 50 micrograms (mcg), two sprays to both nostrils, daily, allergies R5's prescriber order dated April 30, 2024, included the above medication. On March 4, 2025, at 7:12 a.m., the surveyor observed ULP-B hand R5 a Flonase inhaler. R5 stated she needed to blow her nose after administration of Flonase. ULP-B asked R5 if she needed a new tissue. R5 reached in R5's pocket, which contained a tissue. R5 put the inhaler up to her right nostril and sprayed, one, two, three times. R5 placed the inhaler up to her left nostril and sprayed one, two, three times. ULP-B stated, "good job." On March 4, 2025, at 7:28 a.m., the surveyor reviewed R5's MAR with ULP-B. ULP-B stated R5 was "pretty independent." ULP-B stated there was nothing (no directions) for R5 to self-administer Flonase, but ULP-B added it would be good to have that information in R5's record for "newer staff." ULP-B stated she watched R5 administer the Flonase inhaler. On March 4, 2025, at 10:21 a.m., R5's record was reviewed with RN-C. RN-C stated R5 was	01760			

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01760	Continued From page 51 not assessed to self-administer nasal medication. RN-C added R5 had the diagnoses of dementia. RN-C stated Flonase was on R5's MAR and ULPs should administer the medication. RN-C added, if/when residents can self-administer medication there was documentation on the resident's MAR. MANUFACTURER'S INSTRUCTION R8 R8's diagnoses included benign prostatic hyperplasia (BPH/ noncancerous enlargement of the prostate gland causing difficulty urinating). R8's service plan dated May 10, 2023, indicated R8 received medication administration four times daily and PRN. R8's MAR dated March 1, 2025, through March 4, 2025, included: -tamsulosin 0.4 milligram (mg), one capsule by mouth daily, BPH, 8:00 p.m. On March 4, 2025, at 10:25 a.m., the surveyor observed unlicensed personnel (ULP)-G check R8's leg bag. R8 stated he had just emptied the leg bag. ULP-G wet a washcloth and applied cleaner to the washcloth. With gloved hands ULP-G cleaned around the catheter (suprapubic/ device that drains urine from the bladder through belly button or abdomen) entry site with the moistened washcloth. ULP-G wet a clean washcloth and cleaned around the site, to rinse the area. On March 5, 2025, at 11:37 a.m., R8's MAR and manufacturer's instructions for tamsulosin were reviewed with RN-C. RN-C stated she was not aware of the specific instructions for tamsulosin administration. RN-C confirmed R8' tamsulosin	01760			

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01760	Continued From page 52 was not administered per manufacturer's instructions. The manufacturer's instructions for tamsulosin dated January 15, 2018, noted- take tamsulosin 30 minutes after the same meal each day. Follow the directions on your prescription label carefully. The licensee' s Nose Drops & Nasal Spray policy dated August 30, 2021, noted only properly trained staff of the licensee may provide medication assistance or administration. Nasal spray medications must be administered according to the prescriber orders. - compare the information of the MAR with the label on the medication container. The following information should be in all the places: - resident name - name of the medication - the strength and dosage of the medication - the route - the time that the medication was to be given - any special instructions. - provide privacy for the individual. Tell him/ her what you are going to do. The licensee's Medication & Treatment-Administration & Delegation policy dated August 30, 2021, noted when administration of medications was delegated or assigned to unlicensed personnel, the licensee would ensure that the RN had: - instructed the ULP in the proper methods with respect to each resident to administer the medication, 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.	01760			

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01760	Continued From page 53	01760			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was securely stored and permitted only authorized personnel to have access to medication being stored by the licensee for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The assisted living held a dementia care license with a current census of 28 residents. During the entrance conference on March 3, 2025, at 9:31 a.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01880			

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01880	Continued From page 54 and registered nurse (RN)-C, LALD/CNS-A stated all 28 residents at the facility received medication management. R2's diagnosis included Alzheimer's dementia. On March 3, 2025, at 12:51 p.m., the surveyor observed unlicensed personnel (ULP)-B escort R2 to R2's room to get a sweater. The surveyor observed a container of Hempvana pain relief original cream on the vanity, near the sink in R2's bathroom unsecured. On March 3, 2025, at 1:57 p.m., LALD/CNS-A and RN-C went to R2's room and confirmed there was an opened container of Hempvana pain relief cream unsecured. The Hempvana pain relief label was reviewed with LALD/CNS-A which noted, apply to affected area not more than three to four times daily. For external use only, avoid contact with eyes. Do not apply more than four times daily. LALD/CNS-A stated R2's husband must have brought in the cream. LALD/CNS-A stated the Hempvana cream was considered a medication and should have been secured. The licensee's Medication Storage policy dated August 30, 2021, noted medication managed by the licensee would be stored to prevent diversion of medication by residents or others who may have access to the medication. Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medications room, medication cart, or similar setup. No further information was provided.	01880			

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01880	Continued From page 55	01880			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01950 SS=D	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 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 observation, 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 four residents (R4) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01950			

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01950	Continued From page 56 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnosis included diabetes, and dementia. R4's service plan dated September 16, 2021, indicated R4 received Accu-Chek (blood glucose) monitoring daily. On March 4, 2025, at 6:20 a.m., unlicensed personnel (ULP)-F attempted to shower R4. In addition, on March 4, 2025, at 6:36 a.m., ULP-B and ULP-F assisted R4 off the floor and took R4 to her room. R4's medication administration record (MAR) dated March 1, 2025, through March 4, 2025, included: - Accu-Chek twice daily, 7:00 a.m., 7:00 p.m. R4's prescriber order dated March 21, 2024, included the above orders. R4's record did not include specific resident instructions for Accu-Chek parameters. On March 4, 2025, at 1:20 p.m., the surveyor reviewed R4's record with RN-C. RN-C stated she "missed" when and what blood glucose readings should be reported to nursing on R4's MAR. RN-C stated R4's record did not include specific instructions for blood glucose monitoring as required. The licensee's Treatment & Therapy	01950			

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01950	Continued From page 57 Management Plan policy dated August 30, 2021, noted the licensee would develop and maintain current individualized treatment and therapy management record for each resident which must contain at least the following: - documentation of specific resident instructions relating to the treatments or therapy administration. - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services - any resident- specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	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: Based on observation, interview, and record review, the licensee failed to ensure treatments or	01960			

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01960	Continued From page 58 therapies were administered as prescribed for one of two residents, (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 3, 2025, at 9:40 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee offered modified diets to include nutritional diets (low sodium, diabetic). R6's diagnoses included diabetes, mood disorder, and post-traumatic stress disorder (PTSD/flash backs, nightmares, severe anxiety). R6's service plan dated November 28, 2023, indicated R6 received a modified diet, diabetic. Staff responsible was noted "ULP" (unlicensed personnel). R6's prescriber order dated January 3, 2025, included diabetic diet. R6's medication/treatment/therapy management plan dated November 28, 2024, included: -medication administration -medication set-ups -blood glucose checks. R6's Comprehensive Home Care Resource	01960			

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01960	Continued From page 59 Manual- 4.081 form, dated November 28, 2023, authenticated by LALD/CNS-A included: - any client (resident) specific requirements relating to documenting treatments/therapy services are located, on MAR/TAR (medication/treatment administration record) - verification that all treatments/therapy services were administered/carried out as prescribed or ordered is located, on MAR/TAR. R6's MAR and/ or TAR dated March 1, 2025, through March 4, 2025, did not include diabetic diet. R6's monthly ADL (activities of daily living) record dated March 1, 2025, through March 4, 2025, included: - appetite (% ate) breakfast, lunch, dinner. R6's services did not include diabetic diet. On March 5, 2025, at 10:31 a.m., registered nurse (RN)-C stated kitchen staff would not be at the facility 24 hours a day. On March 5, 2025, at 11:10 a.m., R6's record was reviewed with RN-C. RN-C stated R6's diabetic diet should have been on R6's MAR/TAR to alert staff of R6's diabetic diet. RN-C stated the kitchen was aware of R6's diet, but the kitchen was not always there and ULPs got R6's snacks. RN-C stated R6 was the only resident who currently received a specialized diet at the facility. RN-C stated R6's record did not indicate R6 was on a diabetic diet and ULPs may not have been aware. RN-C added another resident at the facility also received blood glucose monitoring and insulin however that resident (R4) was not on a dietetic diet.	01960			

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01960	Continued From page 60 The licensee's Treatment & Therapy Management Plan policy dated August 30, 2021, noted the licensee would develop and maintain current individualized treatment and therapy management record for each resident which must contain at least the following: - documentation of specific resident instructions relating to the treatments or therapy administration. - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services - any resident- specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	02040			

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02040	Continued From page 61 Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted March 5, 2025, at 9:35 a.m., licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and registered nurse (RN)-C, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on March 5, 2025, at 9:40 a.m., LALD-A, DM-D, and RN-C, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

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02070	Continued From page 62	02070			
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents at the facility. This had the potential to affect all 28 residents residing at 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: The licensee held an assisted living dementia care license. The facility was licensed for a capacity of 30 residents and had a current census of 28 residents.	02070			

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02070	Continued From page 63 During the entrance conference on March 3, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff was available at all times for resident care and assistance. LALD/CNS-A stated the night shift was staffed with one unlicensed personnel (ULP) from 11:00 p.m. until 7:00 a.m. The physical layout of the facility included the main entry, which opened into a large common's area. Past the common's area were hallways on both sides leading to resident rooms, bathrooms, and shower rooms. Past the open hallway area was a dining area. There was an enclosed smoking area off the dining area. On March 4, 2025, at 5:55 a.m., the surveyor entered the secured unit via a keypad and observed five residents in the commons area, and one resident ambulating down a hallway. The surveyor observed ULP-F entering the facility from the resident's outdoor smoking area, off the dining area. ULP-F stated the licensee knew he vaped. On March 4, 2025, at 6:32 a.m., ULP-F stated he "maybe" vaped a couple of times on the shift. ULP-F stated, "it may be took two minutes to vape, not five minutes like a cigarette would take". On March 4, 2025, at 7:04 a.m., ULP-F stated he was going to check garbages now and take the trash out. ULP-F stated the trash was out back and someday he (ULP-F) took the trash out before day staff got to the facility. ULP-F stated it "was a quick out and back in." ULP-F stated, "usually not this many people (residents) were awake, but sometimes." ULP-F and the surveyor observed three residents in the commons area at	02070			

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02070	Continued From page 64 that time. On March 4, 2025, at 9:16 a.m., LALD/CNS-A stated ULP-F knew he should not leave the building, "a lot could happen in two minutes". LALD/CNS-A stated ULP-F got paid for the whole shift and should be available. LALD/CNS-A stated that if ULP-F just stood outside the door to vape and he could hear what occurred in the facility that might be allowed. On March 4, 2025, at 2:23 p.m., registered nurse (RN)-C stated ULPs should be allowed to take a break on their shift. R4's contract template dated August 1, 2021, noted in Section three, subd/ 1/ requirements, (12) noted, - ensure that one or more persons were available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: - awake - located in the same building, in an attached building, or on a continuous campus with the facility in order to respond within a reasonable amount of time. R4's Uniform Disclosure of Assisted Living Services and Amenities dated September 9, 2021, included unlicensed staff are in the building and available to respond to resident requests 24/7. The licensee's ALDC (assisted living dementia care) Physical Environment, Fire Protection & Staffing policy dated August 30, 2021, noted an awake staff person will be physically present within secured unit at all times.	02070			

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02070	Continued From page 65 No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070			
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity and choices for one of	02160			

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02160	Continued From page 66 three residents (R4) who resided in the assisted living with dementia care 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia, diabetes, and major depressive disorder. R4's service plan dated September 16, 2021, indicated R4 received the following services: assistance with bathing two to three times weekly and PRN (as needed or as desired). R4's assessment dated February 11, 2024, and February 5, 2025, respectively included: sleeps in later. The undated showering schedule for the facility, authenticated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, noted: per (name-LALD/CNS-A), do not change shower schedule: -R4 nights (11:00 p.m. -7:00 a.m.), Tuesday -R4 afternoons (3:00 p.m. -11:00 p.m.), Friday. On March 4, 2025, at 6:02 a.m., the surveyor observed unlicensed personnel (ULP)-F enter R4's room. ULP-F gently attempted to wake R4. ULP-F stated it was R4's shower day. ULP-F stated if it was not R4's shower day he would let	02160			

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NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719		
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02160	Continued From page 67 her (R4) sleep in. ULP-F stated, he could not make "it up" (shower scheduled on night shift), and added R4 was "about 90 years old." ULP-F stated R4 was not a morning person, and he had told the day shift R4 was not a morning person. On March 4, 2025, at 6:15 a.m., ULP-F stated he hated getting residents up so early. ULP-F stated some days he gets residents up at 5:00 a.m., to get their scheduled showers completed. ULP-F stated there were nights when the night shift had two showers to complete. On March 4, 2025, at 6:20 a.m., ULP-F got R4 into the shower. R4 started to cry and stated she (R4) was cold. ULP-F closed the shower curtain to keep R4 warmer. ULP-F was not able to fully wash R4's body as R4 exited the shower. ULP-F stated he was not sure what he was going to do about R4's shower. ULP-F stated he worked tomorrow also. ULP-F stated day staff had "certain" showers to complete, and afternoons had "certain" showers to complete. ULP-F dressed R4 and assisted R4 out of the shower room. Once outside of the shower room, R4 put herself on the floor. R4 was crying and stated, "oh God, oh God." ULP-B had come into work earlier than scheduled and assisted ULP-F to get R4 to a standing position and back to R4's room. On March 4, 2025, at 9:08 a.m., LALD/CNS-A stated R4 got up during the night often and that R4 "never liked to get up and R4 would never get up if not assisted, R4 would lay in her bed." On March 4, 2025, at 1:00 p.m., LALD/CNS-A stated she forgot about R4's "sleeping in." LALD/CNS-A stated the licensee should have educated ULPs in regard to shower schedules.	02160			

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02160	Continued From page 68 On March 4, 2025, at 1:19 p.m., R4's assessments were reviewed with registered nurse (RN)-C. RN-C stated R4's sleeping habits had not changed. RN-C stated R4's shower was not scheduled in a person-centered way. On March 5, 2025, at approximately 12:20 p.m., LALD/CNS-A stated R4's shower schedule should have been changed a while ago. LALD/CNS-A and RN-C confirmed R4's shower was not done in a person-centered way. R4's record included: Resident Rights Fact Sheet- Assisted Living Licensure Transition dated May 25, 2021, noted assisted living facilities with dementia care license are the only facilities which may have a secured dementia care unit. Facilities with the assisted living facility with dementia care license must provide specialized dementia care services to its resident's. These services include: -providing care and housing to residents in a person-centered manner that promotes each resident's dignity, independence, and comfort -assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitation. R4's contract template dated August 1, 2021, noted in Section three, Subd. 1 noted, utilized a person-centered planning and service delivery process. The licensee's ALDC (assisted living dementia care) philosophy policy dated August 30, 2021, noted the licensee supported person-centered dementia service in the following manner: -philosophy of dementia care services: promotes compassion and concern for each individual -dedicated to enriching the lives of each individual -promotes dignity, respect and purposeful living of	02160			

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02160	Continued From page 69 each individual -promotes choice, self-determination and purposeful living for each individual. The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	02170			

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02170	Continued From page 70 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R4) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4's diagnoses included dementia, diabetes, and major depressive disorder.	02170			

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02170	Continued From page 71 R4's service plan dated September 16, 2021, indicated R4 received the following services: - activities as desired, offered daily. On March 4, 2025, at 6:20 a.m., unlicensed personnel (ULP)-F got R4 into the shower. R4 started to cry stating she was cold. ULP-F closed the shower curtain to keep R4 warmer. ULP-F was not able to fully wash R4's body as R4 exited the shower. ULP-F dressed R4 and assisted R4 out of the shower room. Once outside of the shower room, R4 put herself on the floor. R4 was crying and stated, "oh God, oh God." ULP-B had come into work earlier than scheduled and assisted ULP-F to get R4 to a standing position and back to R4's room. R4's undated resident care plan included: - activities: everyday - encourage socialization - resistive to cares - wanders - secured environment - behaviors off and on through the day - combative with staff at times - smears BM (bowel movement) - pulls curtains down - puts pencils and rags in the toilet. R4's record included an annual activity assessment dated January 2, 2025, noted R4's past and current interests were: - game: dice game, rummy, solitaire - outings: ball games, shopping, lunches - just for fun: music programs - movies: musicals and western movies - reading: newspaper - pets: dogs - sports: basketball	02170			

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02170	Continued From page 72 - other: travel, dancing Bingo, weekly; holiday specials and birthday parties, monthly; 1:1 visits and "friendly" daily. R4 activities assessments noted above did not include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R4's record lacked the development of an individualized activity plan. On March 4, 2025, at 2:16 p.m., the surveyor reviewed R4's record with registered nurse (RN)-C. RN-C stated she was not aware an individualized activity plan was required for each resident with the diagnoses of dementia. RN-C stated the licensee completed the activity form, and gathered the information but the licensee did not go any further with the assessment. RN-C stated an activity plan was not developed that contained all the requirements for the residents with dementia at the facility. The licensee's ALDC (assisted living dementia care) Life Enrichment Programs, Activities & Outdoor Space policy dated August 30, 2021, noted an individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. A selection of daily structured and non-structured activities must be provided and included on the resident activity service or care plan as appropriate. Daily activity options based on	02170			

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02170	Continued From page 73 resident evaluation may include but are not limited to: - occupation or chore related tasks - scheduled and planned events such as entertainment or outings - spontaneous activities for enjoyment or those that may help defuse a behavior - one-to one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music - spiritual, creative, and intellectual activities - sensory stimulation activities - physical activities that enhance or maintain a resident's ability to ambulate or move, and - outdoor activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170			
02310 SS=D	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: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of personal care products in one of four shower rooms.	02310			

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02310	Continued From page 74 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The assisted living held a dementia care license and was a secured unit with a current census of 28 residents. On March 3, 2025, at 10:15 a.m., during a tour of the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-C the surveyor observed in an un-numbered/named unsecured shower room personal care products in an unsecured cabinet. LALD/CNS-A and RN-C observed and confirmed the following: - an opened medicated body powder, "cooling" - an opened Nivea Men sensitive body wash - an opened ProSilk Salon moisturizing 2:1 shampoo and conditioner. Directly after the above observation the labels of the items listed above were reviewed with LALD/CNS-A and RN-C: - medicated body powder, noted warning: for external use only, avoid contact with eyes. Keep out of reach of children. In case of accidental ingestion, get medical help or contact a Poison Control Center right away. - Nivea body wash, noted caution: Keep out of reach of children. For external use only. Avoid contact with eyes.	02310			

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02310	Continued From page 75 - ProSilk noted, Cautions: for external use only, avoid contact with eyes. If contact occurs, rinse eyes with water, use only as directed. On March 3, 2025, at 10:26 a.m., LALD/CNS-A stated the facility had four shower rooms, however only two were currently used. LALD/CNS-A stated she did not "think" about the need to secure such items. LALD/CNS-A commented she did not know who the powder belonged to and threw the powder away. The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02370 SS=D	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two residents (R9) had the right to enter and leave the facility as they chose.	02370			

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02370	Continued From page 76 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living with dementia license for a resident capacity of 30. The facility was secured and required code for the keypad to exit the facility. Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated are or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area. R9's diagnosis included traumatic brain injury (TBI/injury to the brain). R9's service plan dated August 12, 2024, indicated R9 received the following services: - medication administration twice daily and as needed (PRN) - laundry, daily - assistance with hair care, daily - assistance with oral hygiene, setup/monitor - assistance with grooming, daily - assistance with bathing, three times weekly. R9's service plan noted, N/A (not applicable) for	02370			

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02370	Continued From page 77 "I'm OK check" service. R9's assessment for resident vulnerability and safety dated August 12, 2024, and December 2, 2024, respectively included: - orientation to time, place and person: oriented - ability to give accurate information consistently: intact - anxiety/depression/ mental illness: medication - interest in environment and activities: participates - able to ambulant safely with/without assistive devices: independent - range of motions: intact - endurance/strength; intact - chronic conditions/pain/ disability: medication - vision; intact - hearing; intact - touch or smell: intact - speech and communication: intact - able to manage finances: independent - able to follow direction consistently: intact - able to report abuse or neglect: able to report - environment safe/ clean: staff maintains - social support system: monitor -behaviors: medication - alcohol/substance abuse: history of/ monitor Resident is considered vulnerable, but there are no signs of abuse or neglect. Accident/incident reports reviewed included: - dated December 2, 2024, 2:30 p.m.: R9 left the building without telling staff. He (R9) went downtown; stopped at the grocery store, bought snacks, then went to ATM for withdrawal and the to sports club. - dated January 17, 2025, 9:00 p.m., R9 pushed the screen out of his window and climbed out, noted he (R9) was going to Walmart. Brought back by police.	02370			

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02370	Continued From page 78 On March 4, 2025, at 6:05 a.m., unlicensed personnel (ULP)-F stated he had heard R9 had left the facility in the past and R9 now had a GPS (global positioning system) tracker in R9's shoe. On March 4, 2025, at 6:10 a.m., ULP-F stated he had heard police returned R9 to the facility. ULP-F stated the licensee did not know how R9 "got out" (exited the facility). ULP-F stated he looked around and saw footprints in the snow outside of R9's window. ULP-F stated, the prints in the snow looked like a "goat trail." On March 4, 2025, at 11:55 a.m., R9 stated he did not have the code to exit the facility. R9 stated a "neighbor" might have the code to exit the facility. R9 stated he now knew of easier ways to leave the facility then through a window. R9 stated he would call his brother or his sister if and when he wanted to exit the facility. R9 stated he did not have a working phone at the current time. On March 4, 2025, at 12:19 p.m., the surveyor reviewed R9's assessment with registered nurse (RN)-C. RN-C stated she had not completed another assessment after the incident on January 17, 2025, since nothing had changed. RN-C stated they asked that R9 tell staff when he was leaving the facility. RN-C stated R9 should be able to come and go as he wished per assessment and R9's rights had been compromised. On March 4, 2025, at 12:30 p.m., the surveyor asked RN-C about the sign-in/ sign-out ledger, per policy that was located in an accessible and designated area per the licensee's policy. RN-C and the surveyor did not observe a sign-in/ sign-out ledger available for residents.	02370			

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NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719		
(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
02370	Continued From page 79 On March 5, 2025, at 8:36 a.m., the surveyor observed ULP-B administer R9's morning medication. On March 5, 2025, at 12:24 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R9 had the right to come and go. LALD/CNS-A stated R9 had never gone out before, and it was "so cold out." LALD/CNS-A stated she called the police, and the police brought R9 back to the facility. LALD/CNS-A stated the police were not happy with LALD/CNS-A regarding R9. LALD/CNS-A stated R9 had only been out of the facility for approximately one hour. The Minnesota Bill of Rights for Assisted Living Residents dated November 28, 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. The Protecting Resident Rights policy dated August 30, 2021, noted it was the policy of the licensee to protect the rights of their residents. The licensee would not request or required that any resident waive any of the rights provided at any time for any reason, including as a condition of admission. The licensee's Resident Sign In/Out policy dated August 30, 2021, noted a sign-out/sign-in book was located in an accessible and designated area for resident use. All residents were asked to sign out when they left the building and sign in when they return. Residents are asked to inform staff when they are gone over a mealtime, overnight or	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37901	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR		STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719			
(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
02370	Continued From page 80 for an extended period of time. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02370			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living 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) 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:	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37901	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR			STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719		
(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
02430	Continued From page 81 On March 3, 2025, at 9:30 a.m., during the entrance conference with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-C, LALD/CNS-A stated personal cell phones were used for calls or text communication between nursing and unlicensed personnel (ULP). On March 4, 2025, at 6:10 a.m., ULP-F stated he had heard R9 had left the facility, and the police returned R9 to the facility. ULP-F stated the licensee did not know how R9 "got out" (exited the facility). ULP-F stated he looked around and saw footprints in the snow outside of R9's window. ULP-F stated, the prints in the snow looked like a "goat trail." ULP-F stated he texted a picture of the window/trail to nursing with aid of his cell phone. ULP-F stated personal cell phones were used by ULPs as a form of communication. ULP-F stated some of the resident's also called his (ULP-F's) cell phone when they needed assist. On March 4, 2025, at 9:11 a.m., RN-C stated the licensee had a land line and ULPs used their cell phones to text nursing if/as needed. RN-C confirmed personal cell phones were used for communication between ULP to ULP and ULP to nursing and nursing to ULPs. RN-C stated "just normal" texting was used, no secured system was used. RN-C stated it made sense to use a secure system to ensure confidentiality. The licensee's Cell Phones and Personal Calls policy dated August 30, 2021, noted the licensee expects employees and contracted staff to keep cell phones in their locker or designated area allow with any other personal items. Personal calls and cell phones are to be used only during	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37901	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ALTERNATIVE SENIOR		STREET ADDRESS, CITY, STATE, ZIP CODE 511 IRON DRIVE CHISHOLM, MN 55719			
(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
02430	Continued From page 82 break or mealtimes and in designated areas. Using a personal cell phone to take photos of residents or work-related items or events is not permissible. The licensee's Confidentiality policy dated August 30, 2021, noted the licensee took confidentiality of information very serious. Personal, financial, medical, or other private information regarding resident or staff should not be disclosed to any other person except: - as may be required by law - to other staff as appropriate or necessary to provide services - to persons authorized in writing by the resident or resident's responsible person to receive the information, including third party payers, or - to representatives of the commissioner authorized to survey or investigate any part of the community. It is an employee's responsibility to stop co-workers or other staff from discussing inappropriate resident or staff information in public areas. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to have personal, financial, health, and medial information private. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			

Type: Full
Date: 03/12/25
Time: 13:55:00
Report: 7983251065

Food and Beverage Establishment Inspection Report

Page 1

Location:

Aspen Grove Alternative Senior
511 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:

ID #: 0040099
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/22

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.

Surface and Equipment Sanitizers

Chlorine: > 50 at 128 Degrees Fahrenheit
Location: Final rinse of the warewashing machine.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Warewashing Machine
Temperature: 128 Degrees Fahrenheit - Location: Wash and rinse water temperature.
Violation Issued: No

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

Type: Full
Date: 03/12/25
Time: 13:55:00
Report: 7983251065
Aspen Grove Alternative Senior

Food and Beverage Establishment Inspection Report

Page 2

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 7983251065 of 03/12/25.

Certified Food Protection Manager Samantha Clusiau

Certification Number: 11321 Expires: 06/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Samantha Clusiau
Person in Charge

Signed: 7983 _____

Gary Collyard
Public Health Sanitarian III
218-940-9306
gary.collyard@state.mn.us

Type: Full
Date: 03/03/25
Time: 11:00:00
Report: 7983251060

Food and Beverage Establishment Inspection Report

Page 1

Location:

Aspen Grove Alternative Senior
511 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:

ID #: 0040099
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

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.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3

**** Priority 1 ****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

THE QUATERNARY AMMONIUM SANITIZER CONCENTRATION IN THE FINAL RINSE OF THE WAREWASHING MACHINE WAS LESS THAN 100 PPM. SANITIZE IN THE THREE-COMPARTMENT SINK UNTIL THE MACHINE HAS A MINIMUM CONCENTRATION OF 50 PPM OF CHLORINE SANITIZER IN THE FINAL RINSE.

Comply By: 03/03/25

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE CERTIFIED FOOD PROTECTION MANAGER'S CERTIFICATE WAS NOT POSTED.

Comply By: 03/07/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE WAREWASHING MACHINE WAS USING QUATERNARY AMMONIUM AS THE SANITIZER. THE MANUFACTURER OF THE WAREWASHING MACHINE INDICATES ON THE DATA PLATE THAT CHLORINE SANITIZER IS TO BE USED. SANITIZE IN THE THREE-COMPARTMENT

Type: Full
Date: 03/03/25
Time: 11:00:00
Report: 7983251060
Aspen Grove Alternative Senior

Food and Beverage Establishment Inspection Report

SINK UNTIL CORRECTED.

Comply By: 03/03/25

Surface and Equipment Sanitizers

Chlorine: = 100 at N/A Degrees Fahrenheit
Location: Sanitizing compartment of the three-compartment sink.
Violation Issued: No

Chlorine: = 100 at 88 Degrees Fahrenheit
Location: Wiping cloth bucket.
Violation Issued: No

Quaternary Ammonia: < 100 at 121 Degrees Fahrenheit
Location: Final rinse of the warewashing machine.
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Avantco double-door upright freezer was frozen solid.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 38 Degrees Fahrenheit - Location: Roast in the Avantco double-door upright refrigerator.
Violation Issued: No

Process/Item: Reheating
Temperature: 190 Degrees Fahrenheit - Location: Tomato soup.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 121 Degrees Fahrenheit - Location: Wash and rinse water temperature.
Violation Issued: No

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

GENERAL COMMENTS:

- 1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed, and cooling.
- 2) Provided a cooling fact sheet, a temperature requirement fact sheet, and a highly susceptible population fact sheet.
- 3) Demonstrated how to calibrate the food thermometers (3).

Type: Full
Date: 03/03/25
Time: 11:00:00
Report: 7983251060
Aspen Grove Alternative Senior

Food and Beverage Establishment Inspection Report

Page 3

4) Calculated the volume of the sanitizing compartment of the three-compartment sink. There are approximately 1.4 gallons per inch of depth. At a depth of five inches there are approximately 7.0 gallons of water in the sink which requires a minimum of approximately 1.5 tablets (1 tablet in 2.5 gallons of water is 100 ppm). Be sure to use the test strips frequently to confirm proper chlorine sanitizer concentration.

=====

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 7983251060 of 03/03/25.

Certified Food Protection Manager Samantha Clusiau

Certification Number: FM11321 Expires: 06/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Samantha Clusiau
Person in Charge

Signed: 7983 _____

Gary Collyard
Public Health Sanitarian III
218-940-9306
gary.collyard@state.mn.us