Electronically Delivered

April 29, 2024

Licensee
Arkhaven Home Care, LLC
2315 Western Avenue North
Roseville, MN 55113

RE: Project Number(s) SL36748015

Dear Licensee:

On April 15, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 31, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

PMB

Electronically Delivered

February 8, 2024

Licensee
Arkhaven Home Care, LLC
2315 Western Avenue North
Roseville, MN 55113

RE: Project Number(s) SL36748015

Dear Licensee:

On January 23, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 31, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 31, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 31, 2023, found not corrected at the time of the January 23, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:
Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a

maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

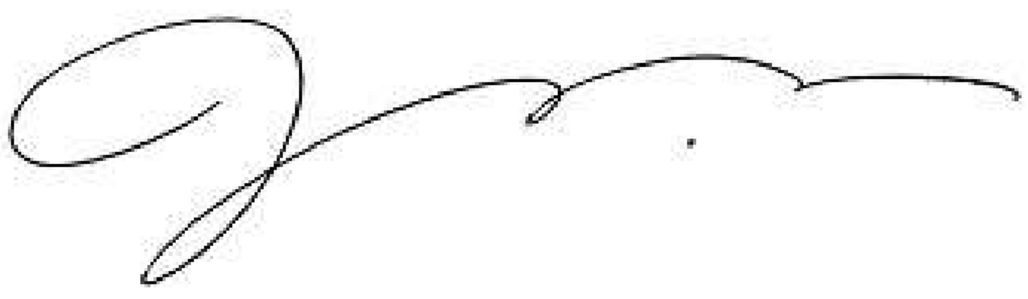
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at jess.schoenecker@state.mn.us.

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

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36748	A. BUILDING: _____ B. WING _____	R 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKHAVEN HOME CARE LLC	2315 WESTERN AVENUE NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36748015-1 On January 23, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 31, 2024. At the time of the survey, there were 4 residents; receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	{0 510}		

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{0 510}	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	{0 680}		

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{0 680}	Continued From page 2 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}		
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee failed to provide resident sleeping rooms with minimum existing emergency escape and rescue window sizes meeting the minimum state standard. This affected the residents in occupied sleeping rooms #2, #3 and #5.	{0 820}		

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{0 820}	Continued From page 3 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 23, 2024, at 3:00 p.m. with administrator (A)-A, it was observed that emergency escape and rescue openings were not provided in occupied resident sleeping room #2, #3, #5 and unoccupied resident sleeping rooms #1. OCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room #2 and #3 emergency escape and rescue clear window opening measurements are 29 inches wide, 19 1/8 inches high and 555 square inches in clear openable area. The windows were measured with A-A and survey staff present. The windows do not meet the minimum requirements for opening height and do not meet the minimum requirements for total openable area. Resident sleeping room #5 emergency escape and rescue clear window opening measurements are 34 inches wide, 17 3/8 inches high 591 square inches in clear openable area. The window was measured with A-A and survey staff present. The window did not meet the minimum requirements for opening height and does not meet the minimum requirements for total openable area.	{0 820}		

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{0 820}	Continued From page 4 UNOCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room #1 emergency escape and rescue clear window opening measurements are 29 inches wide, 19 1/8 inches in high and 555 square inches in clear openable area. The window was measured with A-A and survey staff present. The window did not meet the minimum requirements for opening height and does not meet the minimum requirements for total openable area. It was explained to A-A that at least one emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. During an interview on January 23, 2024, at 3:15 p.m., A-A stated the windows have not yet been replaced but had an estimated date of installation of the new windows within a couple of weeks. It was also observed that a fire watch had continued as evidenced by documentation provided by A-A.	{0 820}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	{0 970}		

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{0 970}	Continued From page 5 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	{01060}		

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{01060}	Continued From page 6 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action needed.	{01060}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	{01640}		

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{01640}	Continued From page 7 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action needed.	{01640}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	{01730}		

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{01730}	Continued From page 8 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action needed.	{01730}		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01820}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	{01940}		

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{01940}	Continued From page 9 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}		
{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	{01960}		

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{01960}	Continued From page 10 ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action needed.	{01960}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action needed.	{01970}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action needed.	{02310}		

Electronically Delivered

December 4, 2023

Licensee
Arkhaven Home Care LLC
2315 Western Avenue North
Roseville, MN 55113

RE: Project Number(s) SL36748015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 the MDH within 15 calendar days of the correction order receipt date.

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

To submit a reconsideration request, please visit:

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

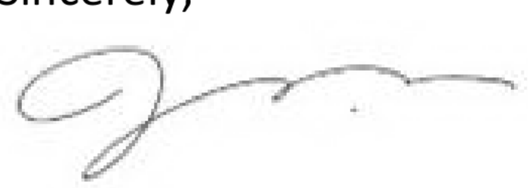
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://www.web.health.state.mn.us/form/HRD-Appeals-Form**.

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36748	A. BUILDING: _____ B. WING _____	10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKHAVEN HOME CARE LLC	2315 WESTERN AVENUE NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36748015-0 On October 30, 2023, through November 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) active residents receiving services under the Assisted Living license. An immediate correction order was identified on October 31, 2023, issued for SL36748015-0, tag identification 0820. On November 1, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloves and surfaces for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 31, 2023, at 10:30 a.m., ULP-B washed hands, entered staff office where R3 sat down on a chair next to the staff desk, applied gloves and checked R3's blood glucose by pricking a finger and obtaining a drop of blood to measure blood glucose in R3's blood. ULP-B	0 510		

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0 510	Continued From page 2 disposed of the blood glucose supplies in the trash, with same gloves on, opened the medication drawer to put the glucometer kit away, removed gloves, and sanitized hands. Evaluator did not observe any surface cleaning on desk after performing the blood glucose. R2 entered and sat down in the same location as R3 where ULP-B used the same surface to check R3's blood presssure. ULP-B applied gloves, set up R2's medications and gave them to R2 to take. With gloves on, ULP-B typed on the keyboard to document the medication administration, removed gloves and sanitized hands. On October 31, 2023, at 12:15 p.m., ULP-B washed hands, applied gloves and entered R1's room. ULP-B obtained the blood glucose by scanning the glucometer to R1's sensor located on R1's left bicep. ULP-B then gave oral medications and administered two different insulins by injecting them into R1's abdomen. Once completed, ULP-B exited room with gloves on, holding a small plastic container which contained the insulin pens, glucometer, and alcohol wipes and attempted to open the office door with gloves on but evaluator stopped ULP-B and opened the door for them. ULP-B then removed the gloves and sanitized hands. On October 31, 2023, at 10:45 a.m., ULP-B stated they wash hands before and after a task. ULP-B stated they removed gloves and sanitized hands before putting the glucometer kit away. ULP-B stated surface cleaning was supposed to be completed right away after a blood glucose check. ULP-B left the office to get cleaning wipes and cleaned the surface. ULP-B's Home Health Aide Competency Evaluation dated October 16, 2021, indicated	0 510		

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0 510	Continued From page 3 ULP-B was competent on infection control/bloodborne pathogens, and maintenance of clean, safe, and healthy environment. The licensee's Infection Control policy dated July 23, 2021, indicated hands are to be washed immediately after gloves are removed. The licensee's Staff Competency policy dated July 23, 2021, indicated all ULPs would be trained and competent on basic infection control, including blood-borne pathogens and maintenance of a clean and safe environment. The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 680		

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0 680	Continued From page 4 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan dated July 23, 2021, did not include the following	0 680		

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0 680	Continued From page 5 required content: - establish and maintain a comprehensive EPP (missing resident plan reviewed quarterly); - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policy and procedures including evacuation related to transportation; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; and -emergency prep testing requirements. On November 1, 2023, at 3:21 p.m., administrator (A)-A stated during annual EPP review, their procedure was to check supplies, train staff on EPP every six months, conduct fire drills, check for facility hazards, check fire extinguishers, have snow removal set up, and that the missing policy review was conducted annually along with other policies. A-A stated they would start reviewing the missing resident policy quarterly and document any changes. The licensee's 1.13 Missing Resident policy dated July 23, 2021, indicated the licensee would review the policy at least quarterly and document any changes. The licensee's 1.4 Emergency Preparedness Plan policy dated 2021, indicated the licensee would include the missing content as required. Minnesota Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under	0 680		

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0 680	Continued From page 6 Code of Federal Regulations, title 42, section 483.73, or successor requirements. The rule referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to 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 an isolated scope (when one or a limited number of	0 800		

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0 800	Continued From page 7 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On a facility tour by phone on October 31, 2023, at 1:30 p.m. with administrator (A)-A it was observed the carpet in resident room #5 had two, one foot by one foot, holes through the carpet to the floor underneath with loose ends causing a trip hazard. On October 31, 2023, at 1:30 p.m., A-A verified this deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 8 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required contents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 1, 2023, administrator (A)-A provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 9 Record review of the available documentation indicated the licensee did not include fire protection procedures necessary for resident instructions for this specific facility in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. Record review of the available documentation indicated evacuation drills had been conducted but not in the required sequence. Documentation for fire drills was provided for March, April and October 2023. Only one drill was completed on morning shift which was in October, all other drills were completed on evening shift. Evacuation drills are required to be completed and documented every other month, twice per shift per year and separately from employee and resident training records. On November 1, 2023, at 10:00 a.m., A-A verified the deficiencies of the fire safety and evacuation plan and drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 10 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee failed to provide resident sleeping rooms with minimum existing emergency escape and rescue window sizes meeting the minimum state standard. This affected the residents in occupied sleeping rooms #2, #3 and #5. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 31, 2023, at 1:30 p.m., with administrator (A)-A, it was observed	0 820	This immediate correction order identified on October 31, 2023, has had the immediacy lifted as of November 1, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 11 that emergency escape and rescue openings were not provided in occupied resident sleeping room #2, #3, #5 and unoccupied resident sleeping rooms #1. OCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room #2 and #3 emergency escape and rescue clear window opening measurements are 29 inches wide, 19 1/8 inches high and 555 square inches in clear openable area. The windows were measured with A-A and survey staff present. The windows do not meet the minimum requirements for opening height and do not meet the minimum requirements for total openable area. Resident sleeping room #5 emergency escape and rescue clear window opening measurements are 34 inches wide, 17 3/8 inches high 591 square inches in clear openable area. The window was measured with A-A and survey staff present. The window did not meet the minimum requirements for opening height and does not meet the minimum requirements for total openable area. UNOCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room #1 emergency escape and rescue clear window opening measurements are 29 inches wide, 19 1/8 inches in high and 555 square inches in clear openable area. The window was measured with A-A and survey staff present. The window did not meet the minimum requirements for opening height and does not meet the minimum requirements for total openable area. It was explained to A-A that at least one	0 820		

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	36748	A. BUILDING: _____ B. WING _____	10/31/2023

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0 820	Continued From page 12 emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. This deficient condition was visually verified by A-A accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate On November 1, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal	0 970		

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0 970	Continued From page 13 property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 30, 2023, at 1:06 p.m., administrator (A)-A provided a blank contract and stated the contract was the current contract used for all residents. The Assisted Living Contract dated 2021, included the following: A clause on page 12, under Miscellaneous Provisions, section one titled "Insurance Liability and Released," indicated "The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee]	0 970		

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0 970	Continued From page 14 from liability for any personal injury or property damage suffered by the resident unless caused by the negligence of [licensee] or its employees or agents." On November 1, 2023, at 9:40 a.m., A-A stated s/he didn't feel it was a waiver of liability because the contract indicated resident would be liable unless it was due to negligence of the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 15 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01060		

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01060	Continued From page 16 R1's Resident Notes dated November 16, 2022, at 11:22 p.m., indicated R1 was sent to the hospital to be evaluated for dehydration and further assessment. There was no documentation on when R1 returned to licensee. R1's Resident Notes dated November 17, 2022, at 10:42 a.m., indicated R1 was to be sent back to the hospital if R1's condition did not improve by November 18, 2022, evening or if R1's condition worsened. R1's Resident Notes dated November 22, 2022, at 5:44 p.m., indicated R1 returned from the hospital. R1's record lacked a written notice with the required statutory content was provided to R1 or to the Office of Ombudsman for Long-Term Care (OOLTC) as noted below: In the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident had been relocated and any new service provider; (3) contact information for the OOLTC; (4) if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and (5) a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 17 (a) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. (b) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. On October 30, 2023, at 3:44 p.m., administrator (A)-A stated in the event a resident needed to be relocated, they would send the incident report and resident profile (includes medication list, vitals and contact information for licensee). A-A stated they were under the impression that requirement was for when a resident didn't return such as a notice of termination. On October 31, 2023, at 9:04 a.m., unlicensed personnel (ULP)-B stated when a resident was sent to the hospital, they sent a folder which contained a resident profile containing resident's emergency contact, medical providers, medical history, medication list, and contact information for licensee. ULP-B was unaware of any other information to be sent with the resident. The licensee's Exhibit 11: Discharge and Transfer of Residents policy dated July 23, 2021, indicated in the event of an emergency relocation, the facility would provide the required information and if the resident has not returned within four (4) days the licensee would contact the Office of	01060		

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01060	Continued From page 18 Ombudsman for Long-Term Care. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R1) service plan was revised to include all services being provided.	01640		

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01640	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type II diabetes, chronic kidney disease, asthma, gastroesophageal reflux disease (GERD), and right below knee amputation. R1's Service Plan signed April 17, 2023, indicated R1 received oxygen management (three times per day), change filter (daily), respiratory equipment care (one time a week), respiratory equipment care (daily), and wound care (daily). OXYGEN R1's Service Recap Summary-Month dated October 2023, indicated unlicensed personnel (ULP) documented under "Oxygen Management," for AM (morning), PM (evening), and overnight, and respiratory equipment care weekly and daily at 11:00 a.m. R1's Assessment As Of Date (nursing assessment) dated October 10, 2023, indicated R1 used two (2) LPM of continuous oxygen, but the service was on hold. During interview on November 1, 2023, at 10:20 a.m., R1 stated s/he needed oxygen when s/he was sick or during chronic obstructive pulmonary	01640		

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01640	Continued From page 20 disease (COPD) flare ups. R1 stated the last time s/he used the oxygen was last month. R1 stated a sleep study was completed a few weeks ago and s/he would be getting a bilevel positive airway pressure (mild air pressure to keep airways open during sleep) machine soon. R1 also stated the oxygen was stored in the garage because there was not room in the bedroom. During interview on November 1, 2023, at 11:03 a.m., administrator (A)-A and surveyor retrieved the oxygen concentrator from the garage and brought it into the house. The concentrator was covered in large particles of dust, tubing still attached which was hard and exposed to contaminates. A-A stated R1 brought the oxygen concentrator out into the garage because there wasn't room in R1's bedroom. On November 1, 2023, at 11:35 a.m., A-A stated if R1 were using the oxygen, staff would do the respiratory equipment service. Surveyor stated the service plan must be updated if the service were no longer being provided and A-A stated they were learning a lot by having this conversation and would get it updated. A-A stated staff were not providing the stated service. During interview on November 1, 2023, at 2:16 p.m., ULP-F stated R1 had not used oxygen since her/his return to the facility around September 26, 2023. WOUND CARE R1's Assessment As Of Date (nursing assessment) dated October 10, 2023, indicated R1's below the knee amputation wound healed, so R1 would be fitted for a prosthesis. On November 1, 2023, at 10:20 a.m., R1 stated	01640		

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01640	Continued From page 21 his/her stump healed June 2023, and did not currently have any other wounds present except for scratches on back from itching. R1 stated s/he would use lotion for the itching. During interview on November 2, 2023, at 12:00 p.m., registered nurse (RN)-C stated R1 did not have any wounds. The licensee's 2.2 Comprehensive Nursing Assessment policy dated July 23, 2021, indicated the RN would conduct a comprehensive assessment for all residents admitted to [licensee] to determine the services required and to develop an individualized care plan for staff to implement. No further information provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 22 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01730		

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01730	Continued From page 23 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During interview with R1 on November 1, 2023, at 10:20 a.m., surveyor observed R1 self-administer eye drops and noted various over-the-counter bottles of medication sitting on R1's dresser within the bedroom. R1's Assessment As Of Date dated October 10, 2023, under "Medications," stated registered nurse (RN)-E assessed R1 needed assistance with an inhaler, topical medications, oral medication administration, insulin injections, and nasal medication and required secured storage for all medications except eye drops which could be self-administered. R1's Service Plan signed on April 16, 2023, indicated R1 received medication administration assistance. R1's Progress Notes dated October 5, 2023, at 3:21 p.m., RN-E documented the medical provider gave an order to allow R1 to manage his/her own vitamins. R1's medication administration record (MAR) dated October 2023, indicated R1 self-administered the following: -bacitracin 500 unit/gram ointment- apply topically to affected areas two times a day; -oxymetazoline 0.05% nasal spray- two sprays into both nostrils two times a day for three days; -pediatric multivitamin-iron 18 milligrams (mg)- chew and swallow one tablet daily; -riboflavin 100 mg- one tablet by mouth daily;	01730		

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01730	Continued From page 24 -cyanocobalamin (vitamin B-12)-100 micrograms (mcg)-one tablet by mouth daily; -folic acid 1 mg- one tablet by mouth daily; -niacin 500 mg- one tablet by mouth two times daily; -pyridoxine (vitamin B-6) 50 mg- one tablet by mouth daily; -sodium chloride 0.65% nasal solution- one spray into both nostrils every two hours as needed; and -Ventolin HFA- inhale two puffs every four hours as needed. R1's medical record lacked the following for each medication: -an assessment by the RN to determine if R1 could self-administer oral over-the-counter medications, topical creams, nasal sprays, and inhalers. On November 2, 2023, at 4:03 p.m., administrator (A)-A stated R1 chose for the licensee to administer certain vitamins. The licensee's 3.2 Assessment of Medications policy dated July 23, 2021, indicated the RN would provide and document a face-to-face assessment with the resident to determine any difficulties with taking the medications. Additionally, the policy indicated the medication management plan would be evaluated/updated as needed with changes in medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 25 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type II diabetes, chronic kidney disease, asthma, gastroesophageal reflux disease (GERD), and right below knee amputation. R1's Service Plan signed April 17, 2023, indicated R1 received assistance with medication administration. R1's After Visit Summary (AVS) dated October 9, 2023, signed by a medical doctor, indicated R1's medications had changed post-operation. The following was an incomplete order and was not on R1's October 2023, medication administration record (MAR):	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36748	A. BUILDING: _____ B. WING _____	10/31/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 26 -naloxone (Narcan)- used to reduce or reverse the effects of opioid overdose. R1's prescriber orders printed on April 10, 2023, ordered R1 to take thiamine (vitamin B-1) 50 milligram (mg) tablet by mouth daily. Next to the order indicated in writing "new." R1's MAR dated October 2023, indicated R1 had received psyllium fiber 0.52 gram (gm) capsule daily. R1's record lacked the following: -complete prescriber orders for naloxone to include strength, route, frequency, and indications for use; -prescriber orders for psyllium fiber; and -documentation that thiamine was given as ordered. On November 2, 2023, at 12:57 p.m., via email, surveyor requested clarification on why naloxone and thiamine were not on R1's MAR. On November 2, 2023, at 3:00 p.m., via email, surveyor requested prescriber order for psyllium fiber and asked again why naloxone and thiamine were not on the MAR. On November 2, 2023, at 3:13 p.m., administrator (A)-A asked where surveyor located orders for naloxone and Thiamine and was confused with things surveyor was asking. At 3:16 p.m., surveyor provided a copy of R1's AVS regarding naloxone. Surveyor did not receive a response verbally or via email regarding the requested clarification/orders. The licensee's 3.1 Medication Management Program Overview policy dated 2021, indicated	01820		

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01820	Continued From page 27 handling and implementing changes to prescriptions, communicating with the pharmacy about the resident's medications, and coordinating and communicating with the prescriber were included in the medication management program. The policy also included for a prescription to be valid it must include the following: -name and quantity of the drug prescribed; and -directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 28 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content and/or revised as needed for one of one resident (R1) receiving oxygen therapy. 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 October 30, 2023, at approximately 10:30 a.m., administrator (A)-A stated the licensee provided treatment or therapy management services for their residents. R1's diagnoses included type II diabetes, chronic kidney disease, asthma, gastroesophageal reflux disease (GERD), and right below knee amputation.	01940		

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01940	Continued From page 29 R1's Service Plan signed April 17, 2023, indicated R1 received assistance with activities, bathing, repositioning, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, compression stockings, oxygen management, behavior management, blood glucose checks, vital sign checks (blood pressure, oxygen saturation, pain, respiration, and temperature), respiratory equipment care, skin treatment, and toileting. R1's provider orders signed October 12, 2022, ordered continuous oxygen two (2) liters per min (LPM) through nasal cannula (tube that brings oxygen to nose). R1's Medication Administration Record (MAR) dated October 2023, lacked oxygen to be administered. R1's Service Recap Summary-Month dated October 2023, indicated unlicensed personnel (ULP) documented under "Oxygen Management," for AM (morning), PM (evening), and overnight. R1's Assessment As Of Date (nursing assessment) dated October 10, 2023, indicated R1 used two (2) LPM of continuous oxygen but it was on hold. R1's resident record lacked a revised treatment or therapy management plan to include all required content: - 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	01940		

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01940	Continued From page 30 problem arises with treatments or therapy services; - any resident-specific requirements relating to documentation of treatment and therapy received; and - verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On November 1, 2023, at 10:20 a.m., R1 stated s/he needed oxygen when s/he was sick or during chronic obstructive pulmonary disease (COPD) flare ups. R1 stated the last time s/he used the oxygen was last month. R1 stated a sleep study was completed a few weeks ago and would be getting a bilevel positive airway pressure (mild air pressure to keep airways open during sleep) machine soon. R1 also stated the oxygen was stored in the garage because there was not room in the bedroom. On November 1, 2023, at 11:03 a.m., A-A stated R1 brought the oxygen concentrator out into the garage because there wasn't room in R1's bedroom. During interview on November 1, 2023, at 2:16 p.m., ULP-F stated R1 had not used oxygen since her/his return to the facility around September 26, 2023. The licensee's Treatment and Therapy Management policy dated July 23, 2021, indicated the registered nurse (RN) would monitor and evaluate the treatment and or therapy effectiveness on a regular basis as specified in	01940		

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01940	Continued From page 31 the service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 document treatment administration, or indicate why the treatment was not administered as ordered, for one of one resident (R1) receiving oxygen therapy. 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).	01960		

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01960	Continued From page 32 The findings include: R1's diagnoses included type II diabetes, chronic kidney disease, asthma, gastroesophageal reflux disease (GERD), and right below knee amputation. R1's Service Plan signed April 17, 2023, indicated R1 received assistance with activities, bathing, repositioning, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, compression stockings, oxygen management, behavior management, blood glucose checks, vital sign checks (blood pressure, oxygen saturation, pain, respiration, and temperature), respiratory equipment care, skin treatment, and toileting. R1's provider orders signed October 12, 2022, ordered continuous oxygen two (2) liters per min (LPM) through nasal cannula (tube that brings oxygen to nose). R1's Medication Administration Record (MAR) dated October 2023, lacked oxygen to be administered. R1's Service Recap Summary-Month dated October 2023, indicated unlicensed personnel (ULP) documented under "Oxygen Management," for AM (morning), PM (evening), and overnight. -28 out of 30 days, it was documented staff administered oxygen to R1 during AM shift; -10 out of 30 days, it was documented staff administered oxygen to R1 during PM shift; and -26 out of 30 days, it was documented staff administered oxygen to R1 during overnight shift.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 33 On November 1, 2023, at 10:20 a.m., R1 stated s/he needed oxygen when s/he was sick or during chronic obstructive pulmonary disease (COPD) flare ups. R1 stated the last time s/he used the oxygen was last month. R1 stated a sleep study was completed a few weeks ago and would be getting a bilevel positive airway pressure (mild air pressure to keep airways open during sleep) machine soon. R1 also stated the oxygen was stored in the garage because there was not room in the bedroom. On November 1, 2023, at 11:03 a.m., administrator (A)-A stated R1 brought the oxygen concentrator out into the garage because there wasn't room in R1's bedroom. On November 1, 2023, at 11:35 a.m., A-A stated it was an error on their end as they should have "held the service." A-A also stated if the staff did not indicate R1 was not on oxygen, then it would be an error. The licensee's Treatment and Therapy Management policy dated July 23, 2021, indicated when a treatment or therapy is not administered as ordered or prescribed, staff would document the reason why it was not administered, and any follow-up procedures provided to meet the residents needs as documented in the treatment plan or as ordered by the prescriber. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

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01970	Continued From page 34	01970		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up to date written or electronically recorded orders were obtained for one of one resident (R1) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 30, 2023, at approximately 10:30 a.m., administrator (A)-A stated the licensee provided treatment or therapy management services for their residents. R1's diagnoses included type II diabetes, chronic kidney disease, asthma, gastroesophageal reflux disease (GERD), and right below knee amputation.	01970		

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01970	Continued From page 35 R1's Service Plan signed April 17, 2023, indicated R1 received assistance with activities, bathing, repositioning, bedmaking, dressing, grooming, housekeeping, laundry, linen change, medication administration, safety check, wheelchair use, compression stockings, oxygen management, behavior management, blood glucose checks, vital sign checks (blood pressure, oxygen saturation, pain, respiration, and temperature), respiratory equipment care, skin treatment, and toileting. On October 31, 2023, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-B check R1's blood glucose, administer oral medications, and inject two different types of insulin. R1's provider orders signed October 12, 2022, ordered continuous oxygen two (2) liters per min (LPM) through nasal cannula (tube that brings oxygen to nose). R1's Medication Administration Record (MAR) dated October 2023, lacked oxygen to be administered. R1's Service Recap Summary-Month dated October 2023, indicated staff documented under "Oxygen Management," for AM (morning), PM (evening), and overnight. R1's Assessment As Of Date (nursing assessment) dated October 10, 2023, indicated R1 used two (2) LPM of continuous oxygen but it was on hold. R1's record lacked a provider order to discontinue the oxygen or change it to as needed.	01970		

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01970	Continued From page 36 On November 1, 2023, at 10:20 a.m., R1 stated s/he needed oxygen when s/he was sick or during chronic obstructive pulmonary disease (COPD) flare ups. R1 stated the last time s/he used the oxygen was last month. R1 stated a sleep study was completed a few weeks ago and would be getting a bilevel positive airway pressure (mild air pressure to keep airways open during sleep) machine soon. R1 also stated the oxygen was stored in the garage because there was not room in the bedroom. On November 1, 2023, at 11:03 a.m., A-A stated R1 brought the oxygen concentrator out into the garage because there wasn't room in R1's bedroom. On November 1, 2023, at 2:16 p.m., ULP-F stated R1 had not used oxygen since her/his return to the facility around September 26, 2023. The licensee's Treatment and Therapy Management policy dated July 23, 2021, indicated when a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered, and any follow-up procedures provided to meet the resident's needs as documented in the care plan or as ordered by the authorized prescriber. The policy also indicated the registered nurse (RN) would monitor and evaluate its effectiveness on a regular basis as specified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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02310	Continued From page 37	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the care and services according to the acceptable health care medical or nursing standards of one of one resident (R1) with oxygen storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 10:00 a.m., upon entry, surveyor observed a designated smoking area to the right corner of the garage facing the street. Surveyor did not observe any "no smoking" or "oxygen in use," signs posted upon entry or within the facility. On October 31, 2023, at 8:45 a.m., surveyor observed R3 sitting just outside the garage service door opposite side of the designated smoking area at approximately ten (10) feet from	02310		

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02310	Continued From page 38 the front entry of the facility. On November 1, 2023, at 11:03 a.m., surveyor accompanied administrator (A)-A into the facility's detached garage through the service door to locate R1's oxygen concentrator (device concentrates oxygen from environment air) which was located toward the back of the garage mixed in other belongings. A-A indicated R1 brought the oxygen concentrator out into the garage because there wasn't enough room to store it in R1's bedroom. When entering the facility from being in the garage, surveyor pointed out that there was no signage indicating oxygen may be in use and A-A asked if the signage should be posted on the R1's door or at the front entry door. The undated Oxlife Independence User Manual indicated if resident was relocating the concentrator from an extreme environment, allow the device to return to the specified operating temperature and humidity ranges before use. The manual also indicated not to expose the battery to excessive heat or cold and to store the battery in a cool dry place when not in use. Lastly, to remove the battery from the device if it would not be used for an extended period of time. The Smoking Regulations document dated July 2016, retrieved from the Minnesota Department of Health (MDH) under Engineering Services-Fire/Life Safety Code Documentation Guide, indicated NO SMOKING signs must be readable from a distance of five (5) feet and posted wherever supplemental oxygen may be stored and/or in use. The licensee's Equipment Safety policy dated July 23, 2021, indicated the licensee would follow the manufacturer's specification and guidelines	02310		

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02310	Continued From page 39 for equipment operation and safety. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *10/30/23*
Time: 12:32:40
Report: 8058231261

Food and Beverage Establishment Inspection Report

Location:
Arkhaven Home Care Llc
2315 Western Avenue North
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0038974
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514786080
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

Hot Water: = --- at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: STRAWBERRY
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TUNA
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES

- TEMPERATURE SENSITIVE STICKERS USED IN DISH MACHINE FALL OFF AND FAIL TO INDICATE TEMP

- REQUESTED PHOTO VIA HRD INSPECTOR - RECEIVED 10/31/23 - VERIFIED TEMP CHANGE TOOK PLACE

-RECOMMEND TRYING DIFFERENT BRANDS OF TEMP SENSITIVE STICKERS OR USE OF ELECTRONIC RECORDING THERMOMETER

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Food and Beverage Establishment Inspection Report

HRD INSPECTOR: ANNA BOHNEN
PIC ESTABLISHMENT: YAHYA ALI

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 8058231261 of 10/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us