



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 15, 2025

Licensee

Adeg Group Home LLC
3229 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36944015

Dear Licensee:

On March 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 11, 2024, and the follow-up survey completed on December 3, 2024. 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 7, 2025

Licensee
ADEG GROUP HOME LLC
3229 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36944015

Dear Licensee:

On December 3, 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 September 11, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 11, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 11, 2024, found not corrected at the time of the December 3, 2024, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on December 3, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

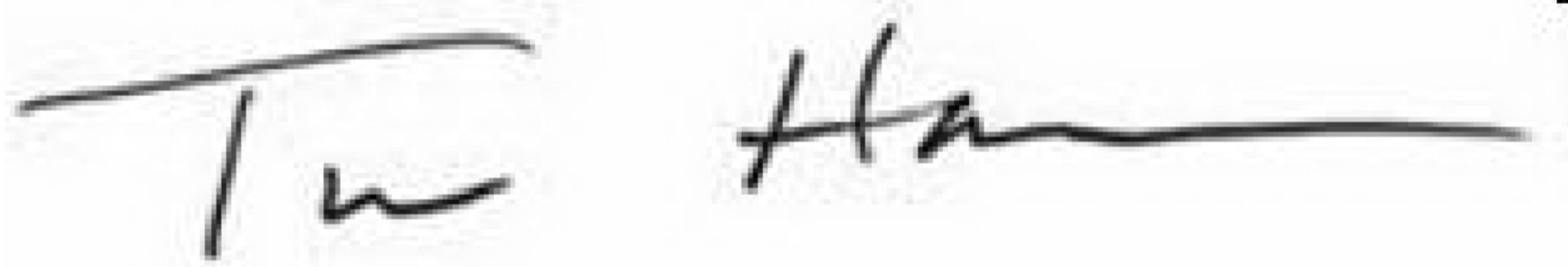
To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is written in a cursive, flowing style with a horizontal line extending from the end.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/03/2024
NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408		
(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, 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: SL#36944015-1 On December 3, 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 September 11, 2024. At the time of the survey, there were 3 active residents; 3 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 SUBDIVISION 1-3.		
{0 470} SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 480}	Continued From page 2 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

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{0 480}	Continued From page 3 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	{0 550}			

Minnesota Department of Health

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{0 650}	Continued From page 4	{0 650}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{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	{0 680}	Not reviewed during this survey.		

Minnesota Department of Health
STATE FORM 6899 VXZT12 If continuation sheet 6 of 16

Minnesota Department of Health

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{0 780}	Continued From page 6	{0 780}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	{0 790}	Not reviewed during this survey.		

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{0 790}	Continued From page 7 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}			
{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;	{0 810}			

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{0 810}	Continued From page 8 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	{0 820}			

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{0 820}	Continued From page 9 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life when the licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 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 December 3, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on September 11, 2024. On December 3, 2024, at 1:15 p.m., the surveyor toured the facility with unlicensed personnel	{0 820}			

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{0 820}	Continued From page 10 (ULP)-D. During the tour, the surveyor asked ULP-D to open the window in the resident bedroom 1 for measurement. The noncompliant measurement was as follows: Unoccupied Sleeping Bedroom 1's window measured approximately 17 inches clear width, 27 inches clear height, and 459 square inches total open area. The window in bedroom 1 did not meet the minimum requirements for clear width and total openable area. On December 3, 2024, at 1:20 p.m., per phone conversation, house manager (HM)-A stated bedroom 1's window had not been replaced. HM-A also stated licensee thought bedroom 1's window size was compliant, and only needed to correct the windowsill height by placing a bed under the window with a thicker mattress. The surveyor explained to HM-A and ULP-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. HM-A and ULP-D verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. No further information was provided.	{0 820}			
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	{01370}			

Minnesota Department of Health

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

Minnesota Department of Health

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{01370}	Continued From page 12	{01370}	Not reviewed during this survey.		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/03/2024
NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01530}	Continued From page 13 (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 14 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 15 This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 14, 2024

Licensee

Adeg Group Home LLC
3229 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36944015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36944015 On September 10, 2024, through September 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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 included: On September 10, 2024, at 1:24 p.m. the surveyor reviewed the postings on the wall near the dining area. The posted staff schedule was dated August 4, 2024, thru August 18, 2024. The surveyor notified house manager (HM)-A, who stated it was not current. The licensee's 4.06 Staffing & Scheduling policy dated March 1, 2023, indicated: 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the	0 550			

Minnesota Department of Health

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0 550	Continued From page 4 individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 10, 2024, at 1:24 p.m. the surveyor toured the facility with house manager (HM)-A. In the office area outside of the dining room was a bulletin board with several postings. Included was the licensee's 2.10 Complaint/Grievance Posting policy. The policy included contact information for the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Office of Health Facility Complaints, and the Minnesota Adult Abuse Reporting Center (MAARC). The policy did not include the procedure on how to file a grievance with the licensee. HM-A stated the posted policy did not contain all required content.	0 550			

Minnesota Department of Health

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0 550	Continued From page 5 The licensee's 2.10 Complaint/Grievance Posting policy dated March 1, 2024, indicated: [Licensee name] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident compliant/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650			

Minnesota Department of Health

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0 650	Continued From page 6 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (house manager (HM)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM-A was hired June 22, 2021, to provide direct care services for the licensee. HM-A's record lacked an annual performance review that identified areas of improvement needed and training needs. On September 10, 2024, at 3:15 p.m. house manager (HM)-A stated his employee record did not include evidence of any annual performance reviews. The licensee's 4.05 Employee Records policy dated March 1, 2023, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided.	0 650			

Minnesota Department of Health

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0 650	Continued From page 7	0 650			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Twenty-One (21) days 144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required	0 680			

Minnesota Department of Health

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0 680	Continued From page 8 elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 10, 2024, at 11:16 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - a description of the population served by the licensee; - procedure for tracking staff and residents; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding	0 680			

Minnesota Department of Health

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0 680	Continued From page 9 the facility's needs, and its ability to provide assistance to include information about their occupancy; and - EP testing/annual testing requirements. On September 11, 2024, at 3:15 p.m. house manager (HM)-A reviewed the emergency preparedness binder and could not find evidence of the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry 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	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
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0 690	Continued From page 10 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's comprehensive assessments dated October 5, 2023, October 14, 2023, and January 14, 2024, were not authenticated with the title of the person completing the assessment. On September 10, 2024, at 3:33 p.m. clinical nurse supervisor (CNS)-B reviewed R1's comprehensive assessments and stated she had signed her name to the assessments; although she had not authenticated them with her title. The licensee's 2.38 Resident Record - Information and Content policy dated March 1, 2023, indicted: All entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780			

Minnesota Department of Health

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0 780	Continued From page 11 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with house manager (HM)-A on	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
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0 780	Continued From page 12 September 10, 2024, between 11:30 a.m. and 1:15 p.m. the following deficient conditions were observed: SMOKE ALARMS: The surveyor observed that the smoke alarm in the basement of the facility was not interconnected. The surveyor explained to HM-A that all the smoke alarms in the facility shall be interconnected. This deficient condition was visually verified by HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790			

Minnesota Department of Health

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0 790	Continued From page 13 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On facility tour with house manager (HM)-A on September 10, 2024, between 11:30 a.m. and 1:15 p.m. the following deficient condition was observed: The portable fire extinguishers throughout the facility needed their annual inspection. The surveyor explained to HM-A that all fire extinguishers shall have the annual inspection completed to meet the state fire code requirements. The deficient condition was visually verified by HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

Minnesota Department of Health

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0 800	Continued From page 14 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with house manager (HM)-A on September 10, 2024, between 11:30 a.m. and 1:15 p.m. the following deficient conditions were observed: ROOF: The surveyor noticed shingles on the ground and few areas on the roof that were missing them. The surveyor explained to HM-A that the shingles	0 800			

Minnesota Department of Health

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0 800	Continued From page 15 shall be replaced and residence shall be kept in good repair. The deficient condition was visually verified by HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 16 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on September 10, 2024, at approximately 1:00 p.m. with house manager (HM)-A on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. FIRE/EVACUATION DRILLS: During record review HM-A stated the fire/evacuation drills were being completed but during record review they were not being documented.	0 810			

Minnesota Department of Health

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0 810	Continued From page 17 TRAINING: During record review, HM-A stated the training on the fire safety and evacuation plan had not been completed and documented for the employees and residents. The surveyor explained to HM-A the employees shall be trained specifically on their fire safety and emergency plan at new hire and twice a year thereafter. Also, the residents shall be offered the training once a year. Both shall be documented. The fire safety and evacuation plan shall be updated and continue to be always updated annually and available within the facility. The fire drills shall be completed twice per year on each shift, at least one every other month and this shall be documented with date, time and signatures of who participated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be 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.	0 820			

Minnesota Department of Health

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0 820	Continued From page 18 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 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On facility tour with house manager (HM)-A on September 10, 2024, between 11:30 a.m. and 1:15 p.m. the following deficient condition was observed: Resident room 1 window measured 17"X27"X52". This room was not occupied. 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. The windowsill height from the floor to the clear opening shall be not more than 48 inches. Surveyor explained to HM-A that at least one compliant emergency escape and rescue opening	0 820			

Minnesota Department of Health

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0 820	Continued From page 19 is required within each resident sleeping room and that a permanent affixed to the wall step or bed shall be placed in front of this window. HM-A stated they would not have a resident sleep in this room until a code compliant escape window is installed. This deficient condition was visually verified by HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
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01370	Continued From page 20 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C, house manager (HM)-A) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on December 5, 2023, to	01370			

Minnesota Department of Health

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01370	Continued From page 21 provide direct care services to residents of the facility. ULP-C's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. HM-A HM-A was hired on June 22, 2021, to provide direct care services to residents of the facility. On September 11, 2024, at 8:32 a.m. HM-A was observed administering medications to R1. HM-A's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. On September 11, 2024, at 1:37 p.m. HM-A stated being unable to find evidence of the above training/competencies for ULP-C or himself. The licensee's 5.02 Competency Training Evaluations policy dated March 1, 2023, indicated: 5. Training and competency evaluations for all ULPs will include: g) Standby assistance techniques and how to perform them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370			
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380			

Minnesota Department of Health

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01380	Continued From page 22 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel ((ULP)-C, house manager (HM)-A) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
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01380	Continued From page 23 ULP-C ULP-C was hired on December 5, 2023, to provide direct care services to residents of the facility. ULP-C's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - safe transfer techniques and ambulation - range of motioning and positioning HM-A HM-A was hired on June 22, 2021, to provide direct care services to residents of the facility. On September 11, 2024, at 8:32 a.m. HM-A was observed administering medications to R1. HM-A's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - safe transfer techniques and ambulation - range of motioning and positioning On September 11, 2024, at 1:37 p.m. HM-A stated being unable to find evidence of the above training/competencies for ULP-C or himself. The licensee's 5.02 Competency Training Evaluations policy dated March 1, 2023, indicated training and competency evaluation for unlicensed personnel providing assisted living services must include: e. Safe transfer techniques and ambulation f. Range of motioning and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training. 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	01530			

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01530	Continued From page 25 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on December 5, 2023, to provide direct care services to residents under the assisted living license. ULP-C's record included five hours of training for dementia topics, but lacked an additional three hours of training to meet the required eight hours within 160 working hours of employment start date. On September 11, 2024, at 11:29 a.m. house manager (HM)-A stated ULP-C worked a 12-hour shift every Saturday and Sunday, and would have exceeded 160 working hours. On September 11, 2024, at 1:37 p.m. HM-A reviewed ULP-C's employee record and stated ULP-D had only completed five hours of dementia training within the required 160 hour timeframe. The licensee's 5.03 Dementia Training policy dated March 1, 2023, indicated: 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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01620	Continued From page 26	01620			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, 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	01620			

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01620	Continued From page 27 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 schizophrenia and anxiety. R1's service plan dated February 24, 2024, included medication administration, behavior management, laundry, and housekeeping. R1's record included a 14-day assessment dated October 14, 2023. R1's next assessment was dated January 14, 2024; 92 days had passed between the assessments (two days late). On September 10, 2024, at 3:33 p.m. clinical nurse supervisor (CNS)-B reviewed R1's assessments and stated the first 90-day assessment had been conducted late. The licensee's 6.01 Assessment, Reviews & Monitoring policy dated March 10, 2023, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided.	01620			

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01620	Continued From page 28	01620			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01910			

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01910	Continued From page 29 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: R2's Discharge Summary dated March 4, 2024, indicated R4 was admitted to the facility on September 28, 2023, and discharged on March 4, 2024. R2's Service Plan dated September 28, 2023, included medication administration. R2's [Licensee name] Home Medication at Discharge form dated March 4, 2024, included medications that had been sent with R2. The document identified the medication name, strength, quantity, and signature of the nurse. The document did not include the prescription number for any of the medications including: gabapentin (anticonvulsant used for seizures, nerve pain and restless leg syndrome), Ventolin inhaler, and Dulera inhaler. On September 11, 2024, at 10:13 a.m. house manager (HM)-A provided the above form to the surveyor. HM-A reviewed the form and stated it did not include the prescription number for R2's listed medications. The licensee's 7.23 Medication Disposal policy dated March 1, 2023, indicated: Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910			

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01910	Continued From page 30 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 09/10/24
Time: 10:29:49
Report: 8044241277

Food and Beverage Establishment Inspection Report

Page 1

Location:

Adeg Group Home LLC
3229 2nd Ave S
Minneapolis, MN55408
Hennepin County, 27

Establishment Info:

ID #: 0043381
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 6124268280
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Cream cheese and deli turkey in fridge drawer measured above 41 degrees F.

Foods moved to upper portion of fridge while on site.

Comply By: 09/10/24

4-500 Equipment Maintenance and Operation

4-501.114A ** Priority 1 **

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

Scented clorox wipes used to sanitize counter tops.

Comply By: 09/10/24

Surface and Equipment Sanitizers

Hot Water: = at 160.0 Degrees Fahrenheit

Location: Dishwasher

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40.1 Degrees Fahrenheit - Location: Milk in fridge

Violation Issued: No

Type: Full
Date: 09/10/24
Time: 10:29:49
Report: 8044241277
Adeg Group Home LLC

Food and Beverage Establishment
Inspection Report

Process/Item: Cold Holding
Temperature: 38.5 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43.4 Degrees Fahrenheit - Location: Cream cheese in fridge drawer
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 44.2 Degrees Fahrenheit - Location: Deli turkey in fridge drawer
Violation Issued: Yes

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

HRD inspection conducted with Nurse Evaluator Wendy Buckholz. Inspection report reviewed on site with Mohamed Abdulahi.

Domestic kitchen consists of vinyl floors, wooden hollow-base cabinets, painted gypsum walls & ceilings, and domestic equipment, including a dishwasher.

Establishment Info: adegcare@gmail.com

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 8044241277 of 09/10/24.

Certified Food Protection Manager Mohamed Y. Abdulahi

Certification Number: FM108981 Expires: 12/19/24

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for Mohamed

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us