



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 8, 2025

Licensee

Vision2020 Group Homes LLC
1805 15th Avenue South
Minneapolis, MN 55404

RE: License Number 416659
Health Facility Identification Number (HFID) 37183
Project Number(s) SL37183015

Dear Licensee:

On November 26, 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 August 2, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective January 8, 2025.**

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 2, 2024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on August 2, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violations noted at the time of this follow-up survey completed on November 26, 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.

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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: SL37183015-1 On November 25 2025, through November 26, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 2, 2024. At the time of the survey, there were three residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{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	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 3 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident assessments, not to exceed 90 calendar days from the last date of the previous assessment for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes, bipolar disorder, depression, anxiety, bacterial skin infection, and had a history of drug abuse receiving methadone (a medication used to treat heroin dependence). R3's Assessment As of Date with a completed by date of August 4, 2024, was identified by licensed assisted living director (LALD)-A as R3's most recent completed RN assessment. A total of 113 calendar days had passed since R3 had an RN assessment completed.	{01620}			

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{01620}	Continued From page 4 R3's Service Plan (Waiver) - Addendum to Contract signed November 24, 2024, indicated R3 required housekeeping, medication administration, and wound care. Additionally, the service plan indicated assessments by a RN could not exceed 90 calendar days from the previous assessment. On November 25, 2024, at 12:01 p.m., LALD-A stated RN-B should have completed an assessment within 90 calendar days after the previous assessment. RN-B was contacted via LALD-A's cell phone and RN-B stated they had missed the assessment notification within the licensee's electronic health record which would have indicated R3's assessment was overdue. RN-B stated the assessment should have been completed on or before November 2, 2024, to ensure the assessment was completed within the licensee's expected timeframe. The licensee's 6.02 Assessment Schedules policy dated June 2021, indicated ongoing resident assessments could not exceed 90 calendar days from the previous assessment. No further information provided.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 4, 2024

Licensee
Vision2020 Group Homes LLC
1805 15th Avenue South
Minneapolis, MN 55404

RE: Conditional License Number 416659
Health Facility Identification Number (HFID) 37183
Project Number(s) SL37183015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 3, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

§ 144G.20.

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$15,000.000. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting - \$3,000.00

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - \$3,000.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$3,000.00

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

days of the correction order receipt date.

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Vision2020 Group Homes LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Vision2020 Group Homes LLC is in substantial compliance.

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Vision2020 Group Homes LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Vision2020 Group Homes LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Vision2020 Group Homes LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Vision2020 Group Homes LLC will contract with an RN to provide consultation concerning all resident(s) to whom Vision2020 Group Homes LLC

provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Vision2020 Group Homes LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Vision2020 Group Homes LLC and MDH must review the RN's credentials and approve the selection. Vision2020 Group Homes LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Vision2020 Group Homes LLC in an effort to help Vision2020 Group Homes LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Vision2020 Group Homes LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Vision2020 Group Homes LLC and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Jodi.Johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:
- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Health Facility Construction Permit:** Vision2020 Group Homes LLC, will replace at Minnesota Department of Labor and Industry (MNDLI) or City with

delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Vision2020 Group Homes LLC, will provide MDH with a copy of the obtained from MNDLI or City with delegated authority.

- f. General Contractor:** Vision2020 Group Homes LLC, must provide the follow to Tim Hanna, Supervisor, at Tim.Hanna@state.mn.us, within 21-days of the date of this notice:

 - I. Name
 - II. License Number (if required)
 - III. Contact Information
- c. Egress Window Requirements:** Vision2020 Group Homes LLC will replace at least one window in resident bedroom #1, meeting the minimum size requirements:

 - i. Must have a minimum openable width of no less than 20 inches
 - ii. Must have a minimum openable height of no less than 20 inches
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square fee).
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
- g. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Vision2020 Group Homes LLC to correct the violations cited during the survey as well as to determine the overall practice of Vision2020 Group Homes LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- h. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- i. Corrective Action Plan:** Vision2020 Group Homes LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete

- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

MDH will determine if Vision2020 Group Homes LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Vision2020 Group Homes LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Vision2020 Group Homes LLC's assisted living facility license, and Vision2020 Group Homes LLC will correct any outstanding violations identified during the survey. If Vision2020 Group Homes LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

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

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

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

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Minnesota Department of Health

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

TITLE

(X6) DATE

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0 000	Continued From page 1 August 1, 2024, issued for SL37183015-0, tag identification 0830. On August 5, 2024, after survey completion, the immediacy of correction order 0830 was removed, however non-compliance remained at a scope and level of F. An immediate correction order was identified on August 1, 2024, issued for SL37183015-0, tag identification 1750. On August 1, 2024, the immediacy of correction order 1750 was removed, however non-compliance remained at a scope and level of I. An immediate correction order was identified on August 1, 2024, issued for SL37183015-0, tag identification 1950. On August 8, 2024, after survey completion, the immediacy of correction order 1950 was removed, however non-compliance remained at a scope and level of I.	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living	0 250			

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0 250	Continued From page 2 services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category.	0 250			

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0 250	Continued From page 3 (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 30, 2024, at 12:15 p.m. licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read	0 250			

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0 250	Continued From page 4 and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in	0 250			

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0 250	Continued From page 5 some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and	0 250			

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0 250	Continued From page 6 procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent on April 11, 2024. The licensee had an assisted living license issued on May 1, 2024, with an expiration date of April 30, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued: 0630, 1370, 1380, 1440, 1620, 1750, 1760, 1770, 1830, 1880, 1910, 1940, 1950, 1960, 1970 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with	0 250			

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0 250	Continued From page 7 Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	0 470			

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0 470	Continued From page 8 by: Based on observation, interview, and document review, the licensee failed to ensure a staffing plan was developed, potentially affecting all licensee's current 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: During facility tour on July 30, 2024, at 2:30 p.m. with licensed assisted living director (LALD)-A, the surveyor observed the staff schedule posted and an undated, document titled Staffing. The document contained the following: - general information describing the role of administrator, registered nurse, direct care staff, activities coordinator, nutrition services staff, housekeeping/laundry staff, maintenance staff, administrative staff, consulting professionals, training and education coordinator; - general information related to the clients needs; and - the following statement, "By having a comprehensive staffing plan that includes a diverse team of qualified professionals, assisted living facilities and group homes can provide high-quality care and support to residents while ensuring compliance with MDH regulations and standards of practice." The Staffing document failed to include:	0 470			

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0 470	Continued From page 9 (i) an evaluation, conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) 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) 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) 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. On July 30, 2024, at 2:32 p.m. LALD-A stated the Staffing document was the facility's staffing plan. LALD-A stated the licensee did not have an activities coordinator, nutrition services staff, housekeeping/laundry staff, maintenance staff, consulting professionals, or a training and education coordinator. LALD-A further stated he was unaware of the required content of a staffing plan and was unaware of the requirement to review it twice a year. No further information was provided.	0 470			

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0 470	Continued From page 10	0 470			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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: 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 August 1, 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			
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630			

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0 630	Continued From page 11 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized abuse prevention plan with all required content for all three residents (R3, R4, R5) residing in the facility. 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: R3 R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes, bipolar disorder, depression, anxiety, bacterial skin infection, and had a history of drug abuse requiring methadone (a medication used to treat heroin dependence) use. On July 31, 2024, at 9:33 a.m. the surveyor	0 630			

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0 630	Continued From page 12 observed licensed assisted living director (LALD)-A complete wound care on R3's right leg and left arm. LALD-A stated R3 refused to go to the wound care clinic and missed so many appointments that the wound care clinic refused to see R3; in addition they were not sending the wound care supplies. LALD-A further stated R3 had a vascular surgery appointment that he refused to go to. As a result, R3's wounds had worsened. On July 31, 2024, at approximately 12:45 p.m. the surveyor interviewed R3 in their room and the surveyor smelled cigarette smoke. R3's Individual Abuse Prevention Plan (IAPP) dated July 13, 2024, indicated R3 had the following needs: - needed cues and reminders for bathing, hygiene, and dressing; and - needed medication management services. The IAPP indicated R3 also had the following needs/challenges; however, there were no interventions listed: - needed nurse follow up on appointments; - R3 was a "non-compliant" smoker; - R3 drinks moderately; - behavior of verbal aggression - "Easily irritable for no apparent reason at times"; - behavior of agitation -"The client gets upset and verbally abusive towards staff and peers at times"; and - "Kept to self; isolative [sic] in his room, and angry for little things". The IAPP indicated R3 was at risk for abusing others indicated by the following comments - "Verbally abusive [sic] staff and peers at times. Staff deescalate client (resident) by having him go to his room or outside for a walk and client	0 630			

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0 630	Continued From page 13 (resident) is easily redirectable". Although R3's IAPP identified there were areas of concern regarding risk for abuse, the IAPP indicated R3 was not at risk for abuse as he "can express himself". R3's comprehensive nursing assessment dated July 31, 2024, indicated the following: - had last been at the emergency room June 7, 2024, for his leg and arm wounds and he was referred to vascular surgery - frequency of doctor visits were as needed - used methadone daily for a history of drug use - needs encouragement to get out of his room as he isolates himself at times - needs daily housekeeping - "Client (resident) gets treatment from outpatient chemical dependence clinic 5 days a week. Client (resident) also go [sic] wound clinic for his legs and L [left] hand wound. Given wound care at home as needed by the house nurse" - "Wound in both legs and left arm followed by PCP [primary care provider] and wound clinic." - "The client (resident) has wounds on both legs and R [right] arm. The client (resident) has been following up with his primary provider and wound clinic. He missed appointments and the wound clinic stopped sending wound supplies. Appointment made and referred to vascular specialist. RN and staff are doing dressing change as needed but client (resident) continues to dig the wound bed by his nail." - venous stasis wounds to both legs and left arm - wound bed was granulation tissue - drainage was serous, clear - wound appears to be infected, yes; finished antibiotics on July 6, 2024, - "Daily cleaning, and wrap with gauze. Follow up with vascular surgery." - managing wound - wound and ostomy care	0 630			

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0 630	Continued From page 14 nurse specialist - resident smokes - resident smokes 6-7 cigarettes a day - disposes of cigarettes in the designated ash tray - resident handles and extinguishes the cigarette safely - the resident can smoke safely, independently and with no interventions. R3's progress notes dated May-July 2024, included entries of being under the influence of drugs, smoking tobacco and eating in his room, removing bandages and picking at his wounds, etc. Staff attempted to educate and redirect R3, but R3 refused and became angry by yelling at the staff. Staff tried to deescalate the behavior, without success. R3 also has wounds that are not healing. R3 refused to follow medical advice with wound care, and wound clinic visits. R4 R4 was admitted on August 1, 2021, with diagnoses that included traumatic brain injury, depression, mood disorder. On July 31, 2024, at 7:09 a.m. LALD-A stated R4 had left the facility at 9:00 p.m. returned at 12:00 a.m., left again at 2:00 a.m., and had not returned to the facility. LALD-A stated R4 frequently did this at the end of the month when he was out of money. Typically, he went to his cousin's or friends' homes and drank alcohol with them; sometimes was gone for a day or two. LALD-A further stated if R4 was gone for more than 24 hours, they notified his case manager and family member. R4's IAPP dated May 4, 2024, indicated the	0 630			

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0 630	Continued From page 15 following: - R4 received medication administration - R4 was at risk for abusing others "Client (resident) has verbally abusive to client and history of alcohol intoxications, redirection is used to minimize risk." - R4 drinks moderately and occasionally. - behavior of aggression - R4 "gets agitated at times when things went in another way than he wants." No interventions were listed. - behavior of physical aggression - R4 "Client (resident) has history of physicals aggression out side home." No interventions were listed. - behavior of verbal aggression - R4 "has a history of verbal aggression with staff and clients." No interventions were listed. Although R4's IAPP identified there were areas of concern regarding risk for abuse, the IAPP failed to identify if R4 was at risk for abuse and interventions to prevent abuse. R4's progress notes dated June-July 2024, included entries of physical altercations with others resulting in injuries and refusing treatment, leaving the facility and returning intoxicated, verbal and threatening altercations with other residents within the facility. In addition, R4 was reported ill on July 10, 2024, and refused treatment. On July 12, 2024, R4 agreed to transport by ambulance to the hospital where he was treated for an infection and to a long-term care center for rehabilitation until July 26, 2024. Upon R4's return to the facility, he refused vital signs check, assessment and medications. R5 R5 was admitted on April 14, 2024, with diagnoses that included bipolar disorder, schizophrenia, degenerative joint disease, and	0 630			

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0 630	Continued From page 16 major depressive disorder. R5's IAPP dated May 30, 2024, indicated the following: - R5 received medication administration and was resistive to taking medications - R5 had daily blood glucose monitoring with staff assistance - Drug use or history of use indicated R5 used substances at times. - R5 smoked outside in the designated area. - agitation - "paranoid and suspicious at times" - physical aggression - "Loud and irritable but redirectable" - repetitive behavior - "[R5] is paranoid occasionally and talks about people are out to get him. He looks suspicious and watchful at times. According to staff these behaviors are mostly noted following a visit of his "friends." Even if he is not using in the group home, staff are suspecting that he could use substances." - paranoia - "Pt is suspicious and talking about people are out to get him." Although R5's IAPP identified there were areas of concern regarding risk for abuse and risk for abusing others, the IAPP failed to identify if R4 was at risk for abuse, was at risk for abusing others, and interventions to prevent abuse. R5's progress notes dated May-July 2024, included entries of refusal of scheduled medications, having friends over drinking alcohol, and smoking tobacco and drugs inside of his room causing paranoia and verbal outbursts toward staff, and refusing scheduled medical appointments. On July 31, 2024, at 11:15 a.m. LALD-A stated R3 was at risk for self-neglect and abuse from others and risk for abuse should have been	0 630			

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0 630	Continued From page 17 addressed on his IAPP. R4 and R5 are at risk for abuse and at risk to abuse others and it should have been addressed on their IAPPs. No additional information was provided. TIME PERIOD OF CORRECTION: Seven (7) Days.	0 630			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680			

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0 680	Continued From page 18 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided a three ring binder identified as the facility's Emergency Preparedness Manual. The licensee's undated, emergency preparedness plan lacked evidence of the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - facility Risk assessment; - arrangements/contracts to re-establish utility services; - all hazards approach with categorized probable risks/hazards by likelihood of occurrence; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - identification of at-risk population needs like maintaining independence, communication,	0 680			

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0 680	Continued From page 19 transportation, supervision and medical care; - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program; - policies and procedures based on the EP, risk assessment and communication plan; - policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary;	0 680			

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0 680	Continued From page 20 - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles. - documentation of all EP training; and - emergency prep testing requirements. - Missing Resident Policy dated July 20, 2021, failed to be reviewed twice a year as required. On August 2, 2024, at 9:02 a.m. licensed assisted living director (LALD)-A stated all information for emergency preparedness was in the licensee's emergency preparedness binder and he was unaware the emergency preparedness plan did not have all the required content.	0 680			

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0 680	Continued From page 21 The licensee had not completed a hazard vulnerability assessment, did not have memorandums of understanding developed, and they facility had not conducted full scale drills. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730			

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0 730	Continued From page 22 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of services was in the resident's record as required for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 730			

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0 730	Continued From page 23 R3 R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received the following services: - bathing assistance daily - manage behavior - anxiety twice a day - manage behavior - other mental health need three days a week - manage behavior - self isolation twice a day - manage behavior - verbal aggression twice a day - manage behavior - depression twice a day - manage behavior - other mental health need twice a day - meal assistance three times a day - medication administration once a week (injection) - medication administration three times a day - medication set up weekly - blood glucose monitoring every other day - vital signs weekly - socialization daily R3's Service Recap Summary for July 1-30, 2024, identified the following: - manage behavior - anxiety - missing documentation nine of 30 days - manage behavior - self isolation twice a day - missing documentation nine of 30 days - manage behavior - verbal aggression twice a day - missing documentation nine of 30 days - manage behavior - depression twice a day - missing documentation nine of 30 days - manage behavior - other mental health need twice a day - missing documentation nine of 30 days - medication administration missing documentation five of 30 days. R4	0 730			

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0 730	Continued From page 24 On July 31, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A stated although R4 had a signed service plan dated August 1, 2021, it did not accurately reflect R1's current services, and LALD-A printed a Service Plan from the electronic record. R4's unsigned, Service Plan printed on July 31, 2024, indicated R3 received the following services: - manage behavior - agitation - manage behavior - anxiety twice a day - manage behavior - self injurious twice a day - manage behavior - verbal aggression twice a day - manage behavior - other mental health need twice a day - meal assistance three times a day - medication administration three times a day - medication set up weekly - vital signs weekly - socialization daily R4's service recap summary for July 1-12, 2024, and July 26-30, 2024, identified the following: - manage behavior - agitation - missing documentation six of 16 days - manage behavior - anxiety twice a day - missing documentation six of 16 days - manage behavior - self injurious twice a day - missing documentation six of 16 days - manage behavior - verbal aggression twice a day - missing documentation six of 16 days - manage behavior - other mental health need three days a week - missing documentation one of six days - medication administration - missing documentation eight of sixteen days - socialization - missing documentation one of 16 days.	0 730			

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0 730	Continued From page 25 - vital signs weekly no documentation of service being provided. R5 R5's unsigned, Service Plan printed on July 31, 2024, indicated R5 received the following services: - bathing assistance every other day - dressing three days a week - grooming two days of week - manage behavior - agitation three days a week - manage behavior - anxiety twice a day - manage behavior - self isolation twice a day - manage behavior - depression twice a day - manage behavior - paranoia twice a day - meal assistance three times a day - medication administration two times a day - medication set up weekly - vital signs monthly - socialization daily R5's Service Recap Summary for July 1-30, 2024, identified the following: - manage behavior - agitation three days a week - missing documentation one of 12 days. - manage behavior - anxiety twice a day - missing documentation eight of 30 days. - manage behavior - self isolation twice a day - missing documentation eight of 30 days. - manage behavior - depression twice a day - missing documentation eight of 30 days. - manage behavior - paranoia twice a day - missing documentation five of 15 days. - medication administration two times a day - missing documentation eight of 30 days. On July 31, 2024, at 12:50 p.m. licensed assisted living director (LALD)-A stated the services had been provided to the residents and they should have been documented.	0 730			

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0 730	Continued From page 26 The licensee's undated, 2.37 Resident Record - Documentation policy indicated "Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident." No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
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;	0 780			

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0 780	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition 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 July 30, 2024, from approximately 12:30 p.m. to 2:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. Survey staff asked LALD-A to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. There was no smoke alarm installed on the ground floor (living room and study level). 4. There was no smoke alarm installed lower level (kitchen and dining room level). 5. The smoke alarms were not interconnected in bedrooms 5, 3, and 0. These deficient conditions were visually verified by LALD-A accompanying on the tour.	0 780			

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0 780	Continued From page 28 On July 30, 2024, at 2:30 p.m., LALD-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. 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, 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	0 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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
0 800	Continued From page 29 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, from approximately 12:30 p.m. to 2:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The following was observed. GENERAL MAINTENANCE: The door to bedroom 4 had a crack running diagonally from the handle to the hinge. The handle and latch were loose in the door leaf. The wall outside bedrooms 4 and 5 had a large impact crater in the drywall. Pieces of the wall were loose, cracked, and able to be removed from the wall exposing the wall cavity to the hallway. The light fixture in bedroom 5 did not have any light bulbs. The stairs down to bedroom 0 had no stair nosing on two of the treads. The edge of the flooring material was exposed and loose causing a potential tripping hazard. On July 30, 2024, at 2:30 p.m., LALD-A stated they understood the above-listed deficiencies. 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	0 810			

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0 810	Continued From page 30 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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	0 810			

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0 810	Continued From page 31 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 July 30, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection	0 810			

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0 810	Continued From page 32 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On July 30, 2024, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was completed or training was scheduled for a future date for staff on the fire safety and evacuation plan. On July 30, 2024, at 2:30 p.m., LALD-A stated staff was assigned training on a third-party	0 810			

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0 810	Continued From page 33 web-based platform that covered basic fire safety principles but was not specific to the facility plan and procedures. LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of the licensee's evacuation drill log, titled "Record of Fire and Tornado Drill, Year 2024", undated, indicated evacuation drills were conducted on January 15, 2024, March 15, 2024, and June 15, 2024. Each drill was conducted at 12:00 p.m. and did not indicate which shift participated in the drill. No other documentation was provided. On July 30, 2024, at 2:30 p.m., LALD-A stated they had lost the documentation for drills completed in 2023. LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=G	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	0 820			

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0 820	Continued From page 34 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident 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 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 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 July 30, 2024, from approximately 12:15 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff asked LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 5: One windows measuring 31 inches clear width, 16 3/4 inches clear height, and 519 1/4 square inches total open area.	0 820	This immediate correction order identified on July 30, 2024, has had the immediacy lifted as of July 31, 2024, however non-compliance remained a scope and level of I.		

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0 820	Continued From page 35 The windows in bedroom 1 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area 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. Survey staff explained to LALD-A 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. On July 30, 2024, survey staff explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they understood the requirements for egress windows. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R3). This had the potential to	0 830			

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0 830	Continued From page 36 affect all staff, residents and visitors of the facility. This resulted in an immediate correction order on August 1, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, at 3:49 p.m. during the facility tour with licensed assisted living director (LALD)-A, LALD-A stated residents were allowed to smoke in the back yard. They used to have a can for the cigarette butts, but currently they didn't have anything. On July 31, 2024, at approximately 1:2:45 p.m. the surveyor interviewed R3 in their room and the surveyor smelled cigarette smoke. R3 admitted to the licensee on August 9, 2022, and resided on the fourth level of the facility. R3's diagnoses included traumatic brain injury, diabetes, bipolar disorder, depression and anxiety. R3's signed Resident Contract for Assisted Living dated May 1, 2024, indicated on page ten, section J, that the resident agrees "Not to smoke in the room, common areas or elsewhere on the facility's premises unless otherwise designated by the facility and not engage in smoking conduct that endangers people or property, even in	0 830			

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0 830	Continued From page 37 designated areas." Attached to the contract was an addendum titled House Rules which identified "Smoking in the Home is not permitted. Smoking is permitted in the outside permitted smoking areas." R3's registered nurse (RN) Assessment dated July 13, 2024, indicated R3 was assessed to smoke safely and independently without intervention. R3's progress notes identified the following: - June 30, 2024, at 7:44 a.m. R3 "continued to smoke tobacco heavily in his room throughout the night, to the point where staff couldn't sit in the living room. [R3] is violating one of the house rules and doesn't care. He became very agitated and verbally aggressive towards the staff when asked to stop smoking. Staff didn't want to argue or escalate the situation, so they left him alone." - July 3, 2024, at 7:13 a.m. R3 "continued to smoke tobacco heavily in his room throughout the night, to the point where staff couldn't sit in the living room. [R3] is violating one of the house rules and doesn't care. He became very agitated and verbally aggressive towards the staff when asked to stop smoking. Staff didn't want to argue or escalate the situation, so they left him alone." - July 7, 2024, at 7:35 a.m. R3 stayed up all night and smoked in his room and refused to listen to staff. - July 8, 2024, at 7:41 a.m. R3 smoked in his room and refused to listen to staff not to smoke in his room. - July 11, 2024, at 7:11 a.m. R3 smoked in his room. Staff kindly asked him to refrain from smoking in the room, but he refused. - July 13, 2024, at 5:57 p.m. RN-B documented R3 Continues to smoke in his room despite multiple reminders. [R3] was made aware that	0 830			

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0 830	Continued From page 38 smoking affects his wound healing process. - July 15, 2024, at 7:37 a.m. "smoked tobacco in his room throughout the night. He yelled and pushed back at the staff when told to stop smoking. [R3] is causing a serious health and safety issues for the staff and other residents. - July 20, 2024, at 6:27 p.m. LALD-A documented "Staff are experiencing health issues from exposure to secondhand smoke and are finding it difficult to manage [R3]'s behavior. Once he finished eating, he smoked tobacco in his room throughout the night. This resulted in staff being exposed to secondhand smoke, which made it difficult for them to breathe and affected their health. [R3]'s actions are creating an unhealthy and challenging living environment. Immediate steps are required to address his behavior and ensure the well-being of both the residents and the staff." - July 21, 2024, at 11:30 p.m. R3 "has been smoking tobacco in his bedroom all day and night. Staff kindly asked him to stop smoking indoors and to use the designated smoking area outside the house. The house smells like tobacco, which is affecting staff's health, causing concern." - July 25, 2024, at 9:15 a.m. R3 smoked in his room all night and refused to go out to smoke. - July 27, 2024, at 7:24 a.m. R3 "stayed up all night smoking in his room, and despite staff requests for him to stop, he refused." - July 29, 2024, at 8:29 a.m. R3 during the night smoked in his room instead of the designated area. On August 1, 2024, at 9:18 a.m. LALD-A stated the licensee was aware of R3's smoking habit and R3 smokes in his room during the night when he doesn't want to come downstairs. LALD-A	0 830			

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0 830	Continued From page 39 stated he had a meeting once about a year ago with R3's case manager and R3's family member. R3 became angry and threatening and the case manager was not helpful. LALD-A further indicated R3 has a new case manager, but the facility has not had a meeting with him to discuss R3's smoking. R3 currently smokes in his room one to two times per night about three times per week, which is an improvement because a year ago it was occurring every day. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830			

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0 830	Continued From page 40 The immediacy for correction order 0830 was not lifted at the time of survey exit. The immediacy was lifted on August 5, 2024, however non-compliance still exists at a scope and level of F.	0 830			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 910			

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0 910	Continued From page 41 R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. R5's Resident Agreement Assisted Living contract was signed by R5 on April 15, 2024. R3, R4, and R5's Resident Agreement Assisted Living contract lacked a written contract to include the provider's health facility identification (HFID) number and authorized agent for the facility. On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)-A stated the contract did not include the HFID number or the authorized agent for all the facility's current residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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
0 920	Continued From page 42 other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. R5's Resident Agreement Assisted Living contract	0 920			

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0 920	Continued From page 43 was signed by R5 on April 15, 2024. R3, R4, and R5's Resident Agreement Assisted Living contract failed to include a disclosure that it does not hold an assisted living facility with dementia care (ALFDC) license as required. On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)-A stated the contract did not include the disclosure that the facility does not hold an ALFDC license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930			

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0 930	Continued From page 44 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. R5's Resident Agreement Assisted Living contract was signed by R5 on April 15, 2024. R3, R4, and R5's Resident Agreement Assisted Living contract identified "Tenants have a right to make a complaint by email, written or verbal communication. These should be directed to AGENCY AND ADDRESS". The contract failed to include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.	0 930			

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0 930	Continued From page 45 On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)-A stated the contract was not individualized to the facility to include the information for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950			

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0 950	Continued From page 46 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. The contract included a section for R3 to list a designated representative and "If Resident declines to name a Designated Representative, Resident please initial here" with a box to initial. A designated representative was not listed and the box was not checked. R3's record lacked evidence R3 had been provided, on a separate page from the contract the verbatim required statement; "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950			

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0 950	Continued From page 47 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R4 R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. The contract included a section for R4 to list a designated representative and "If Resident declines to name a Designated Representative, Resident please initial here" with a box to initial. A designated representative was not listed and the box was not checked. R4's record lacked evidence R4 had been provided, on a separate page from the contract the verbatim required statement; "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R5 R5's Resident Agreement Assisted Living contract was signed by R5 on April 15, 2024. The contract included a section for R5 to list a designated	0 950			

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0 950	Continued From page 48 representative and "If Resident declines to name a Designated Representative, Resident please initial here" with a box to initial and R5 had initialed the box. R5's record lacked evidence R5 had been provided, on a separate page from the contract the verbatim required statement; "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)-A stated he was unaware of the required designated representative verbatim statement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
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 49 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 property for for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. R5's Resident Agreement Assisted Living contract was signed by R5 on April 15, 2024. R3, R4, and R5's Resident Agreement Assisted Living contract contained the following statements: "INDEMNIFICATION Resident will indemnify and hold harmless Landlord, its employees, and agents from and against any and all claims, actions, damages, and	0 970			

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0 970	Continued From page 50 liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." "LIABILITY Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third party providers. Landlord may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Room or on Landlord's premises." On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)-A stated he was aware there should be no waiver of liability in the contract and he thought he had removed the statements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			

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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: (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.	01060			

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01060	Continued From page 52 (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, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R4). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4's progress notes identified the following - July 12, 2024, at 8:32 a.m. "[R4] was unable to get out of bed on his own, so the staff assisted him in getting up to drink and eat. However, [R4] refused to eat. He attempted to drink juice, but his hands started shaking, causing him to drop the bottle on the bed. He then fell back asleep, saying he would try to drink it later. Despite the staff repeatedly asking if he would like to go to the clinic, [R4] refused and said he would go later. - July 12, 2024, at 10:23 a.m. staff continued to encourage R4 to see a doctor, but he refused.	01060			

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01060	Continued From page 53 Staff contacted R4's case manager and emergency contact. - July 12, 2024, at 12:09 p.m. "Staff checked on [R4] again, but his health hadn't improved at all. He still couldn't get up or sit up on his own and refused to go to the hospital. However, staff informed [R4] that 911 would be called, and he agreed. Paramedics arrived at 12:06, talked to him, evaluated his condition, and decided to take him to [hospital] for further evaluation and treatment." - progress notes indicate R4 was hospitalized July 12, 2024. After hospitalization, R4 went to a long term care center for rehabilitation and returned to the facility on July 26, 2024. - July 26, 2024, LALD-A documented "[R4] returned home today after two weeks of hospitalization and rehabilitation. R4's record failed to identify the resident, the resident's representative, and the case manager had been provided, as soon as practicable, a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 54 R4's record also lacked evidence the facility notified the Office of Ombudsman for Long-Term Care of the relocation within four days. On July 31, 2024, at 8:05 a.m. licensed assisted living director (LALD)-A stated he was unaware of the emergency transfer requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01370 SS=F	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			

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01370	Continued From page 55 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 three of three employees (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-C, and ULP-D) completed training and competency evaluations in all required training topics. 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: LALD-A LALD-A was hired on June 1, 2021. On July 30, 2024 at 2:05 p.m. LALD-A was	01370			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
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01370	Continued From page 56 observed administering medications to R3. On July 31, 2024, at 9:25 a.m. LALD-A was observed completing wound care for R3. LALD-A's employee record lacked evidence training and/or competencies had been completed on the following required topics: (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; and (7) standby assistance techniques and how to perform them. ULP-C ULP-C was hired on January 1, 2023. On July 31, 2024, at 9:25 a.m. ULP-C was observed checking R3's blood glucose and at 2:14 p.m. ULP-C was observed administering medications to R3. ULP-C's employee record lacked evidence training and/or competencies had been completed on the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (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;	01370			

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01370	Continued From page 57 (6) training on the prevention of falls; and (7) standby assistance techniques and how to perform them. ULP-D ULP-D was hired August 19, 2022. On July 31, 2024, at 6:45 a.m. upon arrival at the facility, the surveyor observed ULP-D working independently in the facility. ULP-D's employee record lacked evidence training and/or competencies had been completed on the following required topics: (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; (7) standby assistance techniques and how to perform them; and (8) medication, exercise, and treatment reminders. On August 1, 2024, at 7:50 a.m. LALD-A stated the licensee started using an electronic training system and thought it was sufficient. LALD-A was unaware competencies by a registered nurse (RN) were also required. The licensee's undated, 5.02 Competency Training Evaluations identified: "5. Training and competency evaluations for all ULP's will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the	01370			

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01370	Continued From page 58 facility e) 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 iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	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	01380			

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01380	Continued From page 59 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-C, and ULP-D) completed training and competency evaluations in all required training topics. 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: LALD-A LALD-A was hired on June 1, 2021. On July 30, 2024, at 2:05 p.m. LALD-A was observed administering medications to R3 On July 31, 2024, at 9:25 a.m. LALD-A was observed completing wound care for R3. LALD-A's employee record lacked evidence training and/or competencies had been completed on the following required topics: (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380			

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01380	Continued From page 60 ULP-C ULP-C was hired on January 1, 2023. On July 31, 2024, at 9:25 a.m. ULP-C was observed checking R3's blood glucose and at 2:14 p.m., ULP-C was observed administering medications to R3. ULP-C's employee record lacked evidence training and/or competencies had been completed on the following required topics: (1) observing, reporting, and documenting resident status; (2) observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-D ULP-D was hired August 19, 2022. On July 31, 2024, at 6:45 a.m. upon arrival at the facility, the surveyor observed ULP-D working independently in the facility. ULP-D's employee record lacked evidence training and/or competencies had been completed on the following required topics: (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380			

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01380	Continued From page 61 On August 1, 2024, at 7:50 a.m. LALD-A stated the licensee started using an electronic training system and thought it was sufficient. LALD-A was unaware competencies by a registered nurse (RN) were also required. The licensee's undated, 5.02 Competency Training Evaluations identified: "a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440			

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01440	Continued From page 62 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for three of three staff (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-C, and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: LALD-A LALD-A was hired on June 1, 2021. On July 30, 2024 at 2:05 p.m. LALD-A was	01440			

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01440	Continued From page 63 observed administering medications to R3 On July 31, 2024, at 9:25 a.m. LALD-A was observed completing wound care for R3. LALD-A's employee record lacked evidence a RN conducted direct supervision of LALD-A performing delegated nursing or therapy tasks within 30 days after beginning to work for the facility. ULP-C ULP-C was hired on January 1, 2023. On July 31, 2024, at 9:25 a.m. ULP-C was observed checking R3's blood glucose and at 2:14 p.m., ULP-C was observed administering medications to R3. ULP-C's employee record lacked evidence a RN conducted direct supervision of ULP-C performing delegated nursing or therapy tasks within 30 days after beginning to work for the facility. ULP-D ULP-D was hired August 19, 2022. On July 31, 2024, at 6:45 a.m. upon arrival at the facility, the surveyor observed ULP-D working independently in the facility. ULP-D's employee record lacked evidence a RN conducted direct supervision of ULP-D performing delegated nursing or therapy tasks within 30 days after beginning to work for the facility. On August 1, 2024, at 9:03 a.m. LALD-A stated none of the employees' files included	01440			

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01440	Continued From page 64 documentation a RN conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01620 SS=I	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	01620			

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01620	Continued From page 65 by: Based on observation, interview, and record review, the licensee failed to complete wound assessments for one of one resident (R3) resulting in actual harm when R3's wounds worsened. In addition, the licensee failed to complete a comprehensive assessment every 90 days for two of two residents (R3, R4), failed to complete accurate smoking assessments for two of three residents (R3 and R5), and failed to complete a comprehensive assessment post hospitalization for one of one resident (R4). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes, bipolar disorder, depression, anxiety, bacterial skin infection, and had a history of drug abuse receiving methadone (a medication used to treat heroin dependence). On July 31, 2024, at 9:33 a.m. licensed assisted living director (LALD)-A stated R3 had just showered and LALD-A needed to complete wound care. LALD-A was observed completing the following treatment: - Right lower leg wound approximately 2 inches in diameter.	01620			

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01620	Continued From page 66 - sprayed Skintegrity Wound Cleanser on the wound bed - placed a full sheet of Hydrofera Blue dressing on the wound - placed a gauze dressing on top of the Hydrofera Blue dressing - unfolded a gauze dressing and wrapped it around the dressings and the leg - placed an ABD pad on top of the dressing - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. - Left arm wounds: noted four open and weeping wounds and several additional areas that were healed and scarred. - sprayed Skintegrity Wound Cleanser on the wound beds - placed a calcium alginate dressing over the open wounds - placed a gauze dressing on top of the calcium alginate - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. In addition, the surveyor observed two small open and weeping wounds on R3's left lower leg that were open to air. R3's unsigned, physician orders from the wound care clinic on July 11, 2024, identified: - "wound care three times a week with group home nursing staff; we will submit order for supplies thru [home medical supply company]" "- Ok to shower. Do wound care right after. - Do not soak wound in water. No bathtubs, lakes, pools, etc. - Keep nails short and clean - Consider buying wound cleanser called VASHE (Amazon or Walgreens)" "Wound dressing change: Right Anterior lower leg - Cleanse with mild unscented soap and water or	01620			

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01620	Continued From page 67 a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/2 of a piece of 4x5 Hydrofera Blue to wound - Secondary dressing: apply one 5x9 ABD pad; secure with 1/2 roll gauze and medipore tape. - Apply Spandagrip size F from low ankles to knees bilaterally. Change three times a week and PRN [as needed]" "Wound dressing change: Left Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/4 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 7 from base of toes to back of knee - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and medipore tape. - Apply Spandigrip size F from low ankles to knees bilaterally (if able to tolerate) Wound dressing change: Left Anterior Forearm - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply about 1/3 of a piece of 4x5 Hydrofera Blue to wound	01620			

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01620	Continued From page 68 - apply Spandage size 6 to secure - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and Medipore tape. How to mix vinegar solution: - Use white vinegar (available at most stores) - Mix 1 tablespoon vinegar with one cup water - Use multiple clean pieces of gauze soaked in the solution and place the wet saturated gauze all over the affected areas for 10 minutes. Compression: Spandage should stay on 24/7 unless showering. It may be washed and reused for about a week. Spandigrip can be removed at night and put back on in the morning. It may be washed and reused for about a month. R3's unsigned, Service Plan printed on July 31, 2024, failed to identify R3 was receiving wound care. In addition, R3's record lacked a treatment plan for wound care. R3's record included the following assessments: - December 18, 2023; - March 22, 2024, this was 95 days between assessments (five days late); and - July 13, 2024, this was 113 days between assessments (23 days late). R3's most recent comprehensive assessment dated July 31, 2024, indicated the following: - had last been at the emergency room June 7, 2024, for his leg and arm wounds and he was referred to vascular surgery - frequency of doctor visits were as needed - used methadone daily for a history of drug use - needs encouragement to get out of his room as he isolates himself at times	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 69 - needs daily housekeeping - "Client gets treatment from out patient chemical dependence clinic. 5 days a week. Client also go wound clinic for his legs and L hand wound. Given wound care at home as needed by the house nurse" - "Wound in both legs and left arm followed by PCP [primary care provider] and wound clinic." - "The client has wounds on both legs and R arm. The client has been following up with his primary provider and wound clinic. He missed appointments and the wound clinic stopped send [sic] wound supplies. Appointment made and referred to vascular specialist. RN [registered nurse] and staff are doing dressing change as needed but client continues to dig the wound bed by his nail." - venous stasis wounds to both legs and left arm - wound bed was granulation tissue - drainage was serous, clear - wound appears to be infected yes finished antibiotics on July 6, 2024, - "Daily cleaning, and wrap with gauze. Follow up with vascular surgery." - managing wound - wound and ostomy care nurse specialist. R3's progress notes identified the following: - May 2024: there were two notes indicating wound care was completed by staff, and R3 was reminded to keep the wound areas clean and not to scratch the wound areas. - June 2024: there were eight notes indicating the wounds had not shown any signs of improvement and R3 was experiencing severe pain, removing his dressings and picking his wounds with unsanitary hands causing bleeding and further infection. - July 2024: there were two notes indicating R3 removed his dressings and was digging in his	01620			

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01620	Continued From page 70 wound sites. R3 was educated on the effects of smoking causing delayed wound healing as well as encouraged R3 to keep the doctor appointments with the vascular surgeon and wound care clinic. R3's record lacked evidence of routine comprehensive wound assessments. On August 1, 2024, at 7:00 a.m. LALD-A stated there were no additional wound assessments in R3's record. On August 1, 2024, at 12:25 p.m. clinical nurse supervisor (CNS)-B stated R3 had been going to a wound care clinic and CNS-B was completing wound care once a week; however, R3 stopped going to his appointments which resulted in the wound care clinic no longer seeing R3. The licensee did not receive the Flagyl to complete the wound care per the instructions, and the wound care clinic was no longer sending supplies. CNS-B stated the licensee called the wound care clinic, but they did not return the call. R3 had an appointment scheduled with vascular surgery and he did not go to the appointment. No further attempts were made to get R3 to his primary doctor or any other provider for the wound care. CNS-B further stated R3's wounds had worsened. Smoking assessment R3 R3's comprehensive assessment dated July 31, 2024, indicated R3 was able to smoke safely, independently, without intervention. R3's progress notes identified the following: - May 2024: there were four notes indicating R3	01620			

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01620	Continued From page 71 smoked tobacco in his room despite multiple warnings and staff education of it being unsafe. - June 2024: there were eight notes indicating R3 continued to smoke tobacco in his room despite staff reminders and encouragement to smoke in the designated smoking area due to it being unsafe and bothersome to other residents. - July 2024: there were 11 notes indicating R3 continued to smoke tobacco heavily in his room and affecting staff and other residents. In addition, R3's room had food, over-the-counter medications, wires, and a crack pipe lying on the floor. R3 became agitated and argumentative whenever staff spoke to him about his actions and how it affected others and refused to smoke in the designated smoking area. R5 R5 was admitted on April 14, 2024, with diagnoses that included bipolar disorder, schizophrenia, degenerative joint disease, and major depressive disorder. R5 did not have a signed service plan. R5's comprehensive assessment dated May 30, 2024, indicated R5 was able to smoke safely, independently, without intervention. R5's progress notes identified the following: - May 2024: there were three notes indicating R5 was smoking tobacco (with one instance of cannabis) in his room. Staff reminded R5 that smoking indoors was prohibited and he needed to use the designated smoking area. - June 2024: there were five notes indicating R5 continued to smoke tobacco in his room despite staff redirection. - July 2024: there were two notes indicating R5 continued to smoke tobacco in his room despite	01620			

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01620	Continued From page 72 staff redirection. On July 31, 2024, at 11:15 a.m. LALD-A stated the assessments were completed late. The previous CNS had not done them on time. Smoking assessments should have identified R3 and R5's unsafe smoking habits. Post-Hospitalization R4 R4 was admitted on August 1, 2021, with diagnoses that included traumatic brain injury, depression, mood disorder. On July 31, 2024, at 11:15 a.m. LALD-A stated although R4 had a signed service plan dated August 1, 2021, it did not accurately reflect R1's current services, and LALD-A printed a Service Plan from the electronic record. R4's record identified the following comprehensive assessments: - October 26, 2023; - January 31, 2024, this was 97 days between assessments (seven days late); and - May 4, 2024, this was 94 days between assessments (four days late). R4's progress notes identified the following - July 12, 2024: there were progress notes indicating R4 was not able to sit up or get out of bed independently, and was sent to the hospital via ambulance where he was admitted. After hospitalization, R4 went to a long term care center for rehabilitation. - July 26, 2024, at 11:23 p.m. LALD-A documented "[R4] returned home today after two weeks of hospitalization and rehabilitation." "he appeared somewhat weak, getting up slowly and	01620			

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01620	Continued From page 73 not having full control over his body." - July 27, 2024, at 9:55 p.m. CNS-B documented R4 reported doing okay and feeling well, but declined vitals and skin assessment. R4 was noted to be irritable and restless and required frequent redirection from staff. R4 refused morning medications stating "I didn't eat food" but then declined food when offered. On July 31, 2024, at 8:05 a.m. LALD-A stated R4 didn't have any changes when he returned from the hospital. Medications were reviewed and they were the same. Since everything was the same, the facility did not complete a comprehensive assessment to determine if there was a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640			

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01640	Continued From page 74 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's three residents (R3, R4, R5) had a service plan signed by the resident or resident's designated representative and the facility to document agreement on the services to be provided. 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 the residents). The findings include: R3 On July 30, 2024, at 2:05 p.m. licensed assisted living director (LALD)-A was observed administering medication to R3. R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received the following services:	01640			

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01640	Continued From page 75 - bathing assistance daily - manage behavior - anxiety twice a day - manage behavior - other mental health need three days a week - manage behavior - self isolation twice a day - manage behavior - verbal aggression twice a day - manage behavior - depression twice a day - manage behavior - other mental health need twice a day - meal assistance three times a day - medication administration once a week (injection) - medication administration three times a day - medication set up weekly - blood glucose monitoring every other day - vital signs weekly - socialization daily On July 31, 2024, at 11:15 a.m. LALD-A stated R3's record lacked a signed service plan. R4 R4's unsigned, Service Plan printed on July 31, 2024, indicated R3 received the following services: - manage behavior - agitation - manage behavior - anxiety twice a day - manage behavior - self injurious twice a day - manage behavior - verbal aggression twice a day - manage behavior - other mental health need twice a day - meal assistance three times a day - medication administration three times a day - medication set up weekly - vital signs weekly - socialization daily On July 31, 2024, at 11:15 a.m. LALD-A stated	01640			

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01640	Continued From page 76 although R4 had a signed service plan dated August 1, 2021, it did not accurately reflect R1's current services and LALD-A printed a Service Plan from the electronic record. R5 R5's unsigned, Service Plan printed on July 31, 2024, indicated R5 received the following services: - bathing assistance every other day - dressing three days a week - grooming two days of week - manage behavior - agitation three days a week - manage behavior - anxiety twice a day - manage behavior - self isolation twice a day - manage behavior - depression twice a day - manage behavior - paranoia twice a day - meal assistance three times a day - medication administration two times a day - medication set up weekly - vital signs monthly - socialization daily On July 31, 2024, at 1:07 p.m. LALD-A stated R4's record lacked a signed service plan. The licensee's undated, 6.08 Service Plan policy identified "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences." "2. The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident ' s representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed,	01640			

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01640	Continued From page 77 based on resident reassessments and monitoring." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A and two of two unlicensed personnel (ULP-C and ULP-D completed training and competency evaluations for medication administration prior to administering medications. This resulted in an immediate correction order identified on August 1, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01750			

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01750	Continued From page 78 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: LALD-A LALD-A began providing services for the licensee on June 1, 2021. On July 30, 2024, at 2:05 p.m. LALD-A was observed administering medication to R3. LALD-A checked the medication label on the medication, which was set up by the pharmacy, to the medication administration record (MAR), administered the medication, and documented administration. LALD-A's employee file lacked evidence LALD-A had been trained or competency tested by the facility's registered nurse (RN). ULP-C ULP-C began providing services for the licensee on January 1, 2023. On July 31, 2024, at 2:14 p.m. ULP-C was observed administering medication to R3. ULP-C checked the medication label on the medication, which was set up by the pharmacy, to the MAR, administered the medication, and documented administration. On August 1, 2024, at 9:15 a.m. ULP-C removed a pill tray from the file cabinet, checked the MAR, placed the medications into a medicine cup and administered the medications to R3. ULP-C	01750			

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01750	Continued From page 79 stated RN-B had set up the medications in the tray and he knew what the medications were as he worked at the facility for a year. ULP-C documented each individual medication on the MAR. ULP-C stated when he was hired, he completed the online training and staff trained him. ULP-C's employee file indicated ULP-C had completed training through a web based training program on February 22, 2024; however, ULP-C's file lacked evidence ULP-C had been trained or competency tested by the facility's RN. On August 1, 2024, 6:50 a.m. LALD-A stated they used to use different forms for training; however, when the licensee started with the online training program, he thought that was sufficient. ULP-D ULP-D began providing services for the licensee on August 19, 2022. On July 31, 2024, at 6:45 a.m. when the surveyor arrived at the facility, ULP-D was working independently in the home. On August 1, 2024, at 10:26 a.m. LALD-A stated since ULP-D worked the night shift, he doesn't administer medications often; however, if a resident were to stay out late and request their medications upon return to the facility, or if a resident needed an as needed medication, then ULP-D would administer the medications. ULP-D should have been trained on medication administration. ULP-D's employee file lacked evidence ULP-D had been trained or competency tested by the facility's RN.	01750			

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01750	Continued From page 80 The licensee's undated, 7.15 Medication & Treatment - Administration & Delegation policy identified "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [license name] will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On August 1, 2024, the immediacy of was lifted, however non-compliance remained at a scope and level of I.	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760			

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01760	Continued From page 81 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R3). In addition the licensee failed to ensure documentation of medication administration was in the resident's record as required for all three residents (R3, R4, R5) residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 On July 30, 2024, at 2:05 p.m. licensed assisted living director (LALD)-A was observed administering medication to R3. R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received medication administration three times a day. R3's unsigned, after visit summary dated July 12, 2024, included furosemide 20 mg (milligrams) one tablet by mouth once a day for edema	01760			

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01760	Continued From page 82 (swelling in the legs). R3's medication administration record (MAR) for July 1-30, 2024, did not include furosemide. On July 31, 2024, at 1:58 p.m. LALD-A stated he was unaware the furosemide was listed on the after visit summary and was unsure where the order came from. On August 1, 2024, at 6:50 a.m. LALD-A stated he went to the pharmacy on July 31, 2024, to obtain signed physician orders and asked the pharmacist about the furosemide. LALD-A stated the pharmacy made a mistake and they should have filled the medication. R3's E-Script New Prescription Request dated June 7, 2024, (received from the pharmacy after the surveyor request on July 31, 2024) included furosemide 20 mg by mouth daily. In addition, R3's MAR for July 1-30, 2024, identified the following: *July 4, 2024, and July 11, 2024, at 8:00 a.m. the following medications were not documented as administered or refused: - aripiprazole (antipsychotic) - atorvastatin (cholesterol) - cephalexin (antibiotic) - gabapentin (seizure medication also used as a mood stabilizer) - Jardiance (diabetes) - metformin (diabetes) - topiramate (seizure) - venlafaxine (depression) - Vitamin C *July 16, 23, and 24, 2024 at 2:00 p.m. the following medication were not documented as administered or refused:	01760			

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NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 83 - gabapentin *Weekly Ozempic (diabetes) injectable was not documented as administered or refused on July 13, 20, or 27, 2024. R4 R4's unsigned, Service Plan printed on July 31, 2024, indicated R3 received medication administration services. R4's MAR dated July 1-12, 2024, and July 26-30, 2024, identified the following: *July 4, 10, and 11, 2024, at 8:00 a.m. the following medications were not documented as administered or refused: - nicotine patch - divalproex (seizure medication) - levetiracetam (seizure medication) - meloxicam (pain) - naltrexone (used to reduce opioid cravings) - omeprazole (stomach reflux) *July 4, 6, 11, and 27, 2024, at 10:00 p.m. the following medications were not documented as administered or refused: - divalproex - levetiracetam - mirtazapine (antidepressant) - omeprazole R5 R5's unsigned, Service Plan printed on July 31, 2024, indicated R5 received medication administration services. R5's medication administration record dated July 1-30, 2024, identified the following: *July 3, 5, 12, 14, 18, 2024, morning medications, the following medications were not documented as administered or refused: - lisinopril (heart)	01760			

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01760	Continued From page 84 - meloxicam - metformin - vitamin D3 (vitamin) *July 1, 2024, the following medication was not documented as administered or refused: - atorvastatin On July 31, 2024, at 12:50 p.m. LALD-A stated medications had been provided to the residents and they should have been documented as administered or refused. The licensee's undated, 7.08 Medication Management - Administration & Setup policy identified "The nursing staff and unlicensed personnel trained to provide medication administration at [licensee] will document any medication administration provided accurately in each resident record." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication set up was documented for the one resident (R3)	01770			

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01770	Continued From page 85 receiving medication set up service. 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 the potential to affect a large portion or all of the residents). The findings include: On August 1, 2024, at 9:15 a.m. unlicensed personnel (ULP)-C removed R3's medication pill caddy from the file cabinet. ULP-C placed the pills from the a.m. pill compartment into a medication cup. ULP-C then reviewed each medication on the medication administration record (MAR) and documented them as administered. ULP-C stated he knew what the medications were since he had worked at the facility for over a year. The medications in the pill caddy were set up by the nurse since R3 had a medication change. R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes, bipolar disorder, depression, anxiety, bacterial skin infection, and had a history of drug abuse receiving methadone (a medication used to treat heroin dependence). R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received medication set up and medication administration. R3's medical record lacked documentation of the medication set up.	01770			

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01770	Continued From page 86 On July 31, 2024, at 12:01 p.m. licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-B was new to the the facility and the facility's electronic documentation system; therefore, R3's record lacked documentation of medication set up. At 1:38 p.m., LALD-A further stated on July 12, 2024, R3 had a medication change; therefore, CNS-B placed the medications from the pre-set up medication packs received from the pharmacy, into the medication caddy and removed the medication that was discontinued. The licensee's undated, 7.09 Medication Management - Dosage Box Setup policy identified, "When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to renew prescriptions at least every 12 months for one of two residents	01830			

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01830	Continued From page 87 (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 July 30, 2024 at 2:05 p.m. LALD-A was observed administering medications to R3. R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes, bipolar disorder, depression, anxiety, bacterial skin infection, and had a history of drug abuse receiving methadone (a medication used to treat heroin dependence). R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received medication set up and medication administration. R3's Individualized Medication Management Plan dated July 13, 2024, indicated R3 received medication administration. R3's July 1-30, 2024 medication administration record (MAR) indicated the following medication had been administered: - atorvastatin 20 mg take one tablet by mouth daily R3's E-Script (electronic) Rx (prescription) Renewal Response for atorvastatin 20 mg take	01830			

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01830	Continued From page 88 one tablet by mouth daily, was electronically signed on July 20, 2023. On July 31, 2024, at 1:58 p.m. licensed assisted living director (LALD)-A stated R3 often refused to go to appointments so that may be why the physician orders were over a year old. R3's undated, 7.18 Medication & Treatment Orders - Renewal policy identified "Residents who receive medication management services by [Name of AL] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's medications were securely locked permitting only authorized personnel to have access. This had the potential to affect all residents residing in the facility.	01880			

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01880	Continued From page 89 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 July 31, 2024, at 6:45 a.m. unlicensed personnel (ULP)-D escorted the surveyor to the office and opened the unlocked door. The surveyor observed the key was in the lock on the file cabinet containing the medications. The surveyor also observed a medication refrigerator which contained an injectable medication. The medication refrigerator also did not have a lock on it. ULP-D went downstairs to make a phone call to licensed assisted living director (LALD)-A, leaving the room with the unsecured medications unsupervised. On July 31, 2024, at 7:00 a.m. LALD-A stated the lock to the file cabinet broke "last week," and staff should have the office door locked when they were not in the room. The licensee's undated, 7.11 Medication Storage policy indicated medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01910	Continued From page 90	01910			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or 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 all required information in the resident's record upon disposition of medications 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 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	01910			

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01910	Continued From page 91 of the residents). The findings include: R2's record included a discharge care plan that indicated R2 discharged from the facility on November 2, 2024. R2 received medication administration while residing at the facility. R2's record lacked record of medication disposition upon R2's death. On July 30, 2024, at 2:15 p.m. licensed assisted living director (LALD)-A stated there was no disposition of R2's medications documented. The previous registered nurse must have taken them to a drug disposal drop box and did not document it. LALD-A was unaware of the required documentation upon disposition of medications. The licensee's undated, 7.23 Medication Disposal policy indicated the following: - 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. - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure it developed an individual treatment management plan to include all required content for two treatments	01940			

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01940	Continued From page 93 being provided to the licensee's one resident (R3) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 Wound care On July 31, 2024, at 9:33 a.m. licensed assisted living director (LALD)-A stated R3 had just showered and the wound dressings needed to be put back on. LALD-A was observed completing the following treatment: - Right lower leg wound approximately 2 inches in diameter. - sprayed Skintegrity Wound Cleanser on the wound bed - placed a full sheet of Hydrofera Blue dressing on the wound - placed a gauze dressing on top of the Hydrofera Blue dressing - unfolded a gauze dressing and wrapped it around the dressings and the leg - placed an ABD pad on top of the dressing - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. - Left arm wounds: noted four open and weeping wounds and several additional areas that were healed and scarred. - sprayed Skintegrity Wound Cleanser on the wound beds - placed a calcium alginate dressing over the open wounds	01940			

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01940	Continued From page 94 - placed a gauze dressing on top of the calcium alginate - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. In addition, the surveyor observed two small open and weeping wounds on R3's left lower leg that were open to air. R3's unsigned, physician orders from the wound care clinic on July 11, 2024, identified: - "wound care three times a week with group home nursing staff; we will submit order for supplies thru [home medical supply company]" "- Ok to shower. Do wound care right after. - Do not soak wound in water. No bathtubs, lakes, pools, etc. - Keep nails short and clean - Consider buying wound cleanser called VASHE (Amazon or Walgreens)" "Wound dressing change: Right Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/2 of a piece of 4x5 Hydrofera Blue to wound - Secondary dressing: apply one 5x9 ABD pad; secure with 1/2 roll gauze and medipore tape. - Apply Spandagrip size F from low ankles to knees bilaterally. Change three times a week and PRN [as needed]" "Wound dressing change: Left Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology	01940			

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01940	Continued From page 95 - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/4 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 7 from base of toes to back of knee - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and medipore tape. - Apply Spandigrip size F from low ankles to knees bilaterally (if able to tolerate) Wound dressing change: Left Anterior Forearm - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply about 1/3 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 6 to secure - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and Medipore tape. How to mix vinegar solution: - Use white vinegar (available at most stores) - Mix 1 tablespoon vinegar with one cup water - Use multiple clean pieces of gauze soaked in the solution and place the wet saturated gauze all over the affected areas for 10 minutes. Compression: Spandage should stay on 24/7 unless showering. It may be washed and reused for about a week. Spandigrip can be removed at night and put back on in the morning. It may be washed and reused for about a month.	01940			

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01940	Continued From page 96 R3's unsigned, Service Plan printed on July 31, 2024, failed to identify R3 was receiving wound care. R3's record lacked a treatment plan for R3's wound care to include the following required content: (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. R3 blood glucose monitoring On July 31, 2024, at 9:25 a.m. unlicensed personnel (ULP)-C was observed checking R3's blood glucose. R3's unsigned, Service Plan printed on July 31, 2024, indicated R3 received blood glucose monitoring; however, R3's record lacked the following required content in the blood glucose monitoring treatment plan: (2) documentation of specific resident instructions	01940			

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01940	Continued From page 97 relating to the treatments or therapy administration; (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. On August 1, 2024, at 7:00 a.m. LALD-A stated wound care was not being documented in R3's record, there was no treatment plan with the required content for the wound care. The blood glucose monitoring was on the unsigned, service plan; however, there were no specific instructions for the blood glucose monitoring or any instructions for when to notify a nurse. On August 1, 2024, at 12:25 p.m. clinical nurse supervisor (CNS)-B stated he was unaware of the required content of a treatment plan. The licensee's undated, 7.05 Treatment & Therapy Management Plan policy identified the following: "[The licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy	01940			

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01940	Continued From page 98 administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. 2. The treatment or therapy management record must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940			
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950			

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01950	Continued From page 99 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A and two and two unlicensed personnel (ULP-C, ULP-D) completed training and competency evaluations for the licensees one resident (R3) receiving wound care. This resulted in an immediate correction order identified on August 1, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LALD-A LALD-A began providing services for the licensee on June 1, 2021. On July 31, 2024, at 9:33 a.m. LALD-A stated R3 had just showered and the wound dressings needed to be put back on. LALD-A was observed completing the following treatment: - Right lower leg wound approximately 2 inches in	01950			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
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01950	Continued From page 100 diameter. - sprayed Skintegrity Wound Cleanser on the wound bed - placed a full sheet of Hydrofera Blue dressing on the wound - placed a gauze dressing on top of the Hydrofera Blue dressing - unfolded a gauze dressing and wrapped it around the dressings and the leg - placed an ABD pad on top of the dressing - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. - Left arm wounds: noted four open and weeping wounds and several additional areas that were healed and scarred. - sprayed Skintegrity Wound Cleanser on the wound beds - placed a calcium alginate dressing over the open wounds - placed a gauze dressing on top of the calcium alginate - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. In addition, the surveyor observed two small open and weeping wounds on R3's left lower leg that were open to air and no dressings were applied. R3's unsigned, physician orders from the wound care clinic on July 11, 2024, identified: - "wound care three times a week with group home nursing staff; we will submit order for supplies thru [home medical supply company]" "- Ok to shower. Do wound care right after. - Do not soak wound in water. No bathtubs, lakes, pools, etc. - Keep nails short and clean - Consider buying wound cleanser called VASHE (Amazon or Walgreens)" "Wound dressing change: Right Anterior lower leg	01950			

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01950	Continued From page 101 - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/2 of a piece of 4x5 Hydrofera Blue to wound - Secondary dressing: apply one 5x9 ABD pad; secure with 1/2 roll gauze and medipore tape. - Apply Spandagrip size F from low ankles to knees bilaterally. Change three times a week and PRN [as needed]" "Wound dressing change: Left Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/4 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 7 from base of toes to back of knee - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and medipore tape. - Apply Spandigrip size F from low ankles to knees bilaterally (if able to tolerate) Wound dressing change: Left Anterior Forearm - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply about 1/3 of a piece of	01950			

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01950	Continued From page 102 4x5 Hydrofera Blue to wound - apply Spandage size 6 to secure - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and Medipore tape. How to mix vinegar solution: - Use white vinegar (available at most stores) - Mix 1 tablespoon vinegar with one cup water - Use multiple clean pieces of gauze soaked in the solution and place the wet saturated gauze all over the affected areas for 10 minutes. Compression: Spandage should stay on 24/7 unless showering. It may be washed and reused for about a week. Spandigrip can be removed at night and put back on in the morning. It may be washed and reused for about a month. R3's medical record lacked a a signed service plan or a treatment plan with specific instructions for ULP to complete wound care. LALD-A's employee file lacked evidence LALD-A had been trained or competency tested by the facility's registered nurse (RN) to provide wound care to R3. ULP-C ULP-C began providing services for the licensee on January 1, 2023, and worked independently in the home. ULP-C's employee file lacked evidence ULP-C had been trained or competency tested by the facility's RN to provide wound care to R3. ULP-D ULP-D began providing services for the licensee	01950			

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01950	Continued From page 103 on August 19, 2022. On July 31, 2024, at 6:45 a.m. when the surveyor arrived at the facility, ULP-D was working independently in the home. ULP-D's employee file lacked evidence ULP-D had been trained or competency tested by the facility's RN to provide wound care to R3. On August 1, 2024, at 12:14 p.m. LALD-A stated all staff should be trained and competency tested for the wound care in case it needs to be completed as needed. On August 1, 2024, at 12:25 p.m. RN-B stated when R3 was going to the wound care clinic, the dressing changes were completed there and the RN completed it once a week. Since R3 stopped going to the wound care clinic, the staff have completed the dressing changes. The facility never received the Flagyl and never received the ordered wound care supplies. A call was made to the wound care clinic regarding supplies and they did not call back. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy for correction order 1950 was not lifted at the time of survey exit. The immediacy was lifted on August 8, 2024, however non-compliance still exists at a scope and level of F.	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960			

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01960	Continued From page 104 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment documentation was completed for the licensee's one resident (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 July 31, 2024, at 9:33 a.m. licensed assisted living director (LALD)-A stated R3 had just showered and the wound dressings needed to be put back on. LALD-A was observed completing the following treatment: - Right lower leg wound approximately 2 inches in diameter. - sprayed Skintegrity Wound Cleanser on the	01960			

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01960	Continued From page 105 wound bed - placed a full sheet of Hydrofera Blue dressing on the wound - placed a gauze dressing on top of the Hydrofera Blue dressing - unfolded a gauze dressing and wrapped it around the dressings and the leg - placed an ABD pad on top of the dressing - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. - Left arm wounds: noted four open and weeping wounds and several additional areas that were healed and scarred. - sprayed Skintegrity Wound Cleanser on the wound beds - placed a calcium alginate dressing over the open wounds - placed a gauze dressing on top of the calcium alginate - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. In addition, the surveyor observed two small open and weeping wounds on R3's left lower leg that were open to air. R3's unsigned, physician orders from the wound care clinic on July 11, 2024, identified: - "wound care three times a week with group home nursing staff; we will submit order for supplies thru [home medical supply company]" "- Ok to shower. Do wound care right after. - Do not soak wound in water. No bathtubs, lakes, pools, etc. - Keep nails short and clean - Consider buying wound cleanser called VASHE (Amazon or Walgreens)" "Wound dressing change: Right Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser	01960			

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01960	Continued From page 106 - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/2 of a piece of 4x5 Hydrofera Blue to wound - Secondary dressing: apply one 5x9 ABD pad; secure with 1/2 roll gauze and medipore tape. - Apply Spandagrip size F from low ankles to knees bilaterally. Change three times a week and PRN [as needed]" "Wound dressing change: Left Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/4 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 7 from base of toes to back of knee - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and medipore tape. - Apply Spandigrip size F from low ankles to knees bilaterally (if able to tolerate) Wound dressing change: Left Anterior Forearm - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply about 1/3 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 6 to secure	01960			

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01960	Continued From page 107 - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and Medipore tape. How to mix vinegar solution: - Use white vinegar (available at most stores) - Mix 1 tablespoon vinegar with one cup water - Use multiple clean pieces of gauze soaked in the solution and place the wet saturated gauze all over the affected areas for 10 minutes. Compression: Spandage should stay on 24/7 unless showering. It may be washed and reused for about a week. Spandigrip can be removed at night and put back on in the morning. It may be washed and reused for about a month. R3's unsigned, Service Plan printed on July 31, 2024, failed to identify R3 was receiving wound care. R3's record lacked a treatment plan for R3's wound care. R3's comprehensive assessment dated July 31, 2024, indicated the following: - had last been at the emergency room June 7, 2024, for his leg and arm wounds and he was referred to vascular surgery - frequency of doctor visits were as needed - "Client also go wound clinic for his legs and L hand wound. Given wound care at home as needed by the house nurse" - "Wound in both legs and left arm followed by PCP and wound clinic." - "The client has wounds on both legs and R arm. The client has been following up with his primary provider and wound clinic. He missed appointments and the wound clinic stopped send wound supplies. Appointment made and referred to vascular specialist. RN and staff are doing	01960			

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01960	Continued From page 108 dressing change as needed but client continues to dig the wound bed by his nail." - venous stasis wounds to both legs and left arm - wound bed was granulation tissue - drainage was serous, clear - wound appears to be infected yes finished antibiotics on July 6, 2024, - "Daily cleaning, and wrap with gauze. Follow up with vascular surgery." - managing wound - wound and ostomy care nurse specialist R3's progress notes included information regarding wound care on the following dates: - May 11, 25, 2024 - June 7, 15, 20, 23, 24, 27, 29, 2024 - July 12, 2024, at 4:00 p.m. R3 had an appointment at the clinic. - July 13, 21, 2024 On July 31, 2024, at 1:58 p.m. LALD-A stated R3's wound care was not being documented. On August 1, 2024, at 12:25 p.m. clinical nurse supervisor (CNS)-B stated when R3 was going to the wound care clinic, the dressing changes were completed there, and CNS-B completed it once a week. Since R3 stopped going to the wound care clinic, the staff have completed the dressing changes. The facility never received the Flagyl and never received the ordered wound care supplies. CNS-B stated A call was made to the wound care clinic regarding supplies but they did not call back. CNS-B documented wound care in the progress notes and on his 90 day assessments but no other documentation was being completed. The licensee's undated, 2.37 Resident Record - Documentation policy identified staff providing	01960			

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01960	Continued From page 109 assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded order from an authorized prescriber was obtained for treatments provided the licensee's one resident (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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).	01970			

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01970	Continued From page 110 The findings include: On July 31, 2024, at 9:33 a.m. licensed assisted living director (LALD)-A stated R3 had just showered and the wound dressings needed to be put back on. LALD-A was observed completing the following treatment: - Right lower leg wound approximately 2 inches in diameter. - sprayed Skintegrity Wound Cleanser on the wound bed - placed a full sheet of Hydrofera Blue dressing on the wound - placed a gauze dressing on top of the Hydrofera Blue dressing - unfolded a gauze dressing and wrapped it around the dressings and the leg - placed an ABD pad on top of the dressing - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. - Left arm wounds: noted four open and weeping wounds and several additional areas that were healed and scarred. - sprayed Skintegrity Wound Cleanser on the wound beds - placed a calcium alginate dressing over the open wounds - placed a gauze dressing on top of the calcium alginate - used a strip of tubular netting to tie around the leg on top of the dressing to hold it in place. In addition, the surveyor observed two small open and weeping wounds on R3's left lower leg that were open to air. R3's unsigned, physician orders from the wound care clinic on July 11, 2024, identified: - "wound care three times a week with group home nursing staff; we will submit order for	01970			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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
01970	Continued From page 111 supplies thru [home medical supply company]" "- Ok to shower. Do wound care right after. - Do not soak wound in water. No bathtubs, lakes, pools, etc. - Keep nails short and clean - Consider buying wound cleanser called VASHE (Amazon or Walgreens)" "Wound dressing change: Right Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/2 of a piece of 4x5 Hydrofera Blue to wound - Secondary dressing: apply one 5x9 ABD pad; secure with 1/2 roll gauze and medipore tape. - Apply Spandagrip size F from low ankles to knees bilaterally. Change three times a week and PRN [as needed]" "Wound dressing change: Left Anterior lower leg - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply 1/4 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 7 from base of toes to back of knee - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and medipore tape. - Apply Spandigrip size F from low ankles to knees bilaterally (if able to tolerate)	01970			

Minnesota Department of Health

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01970	Continued From page 112 Wound dressing change: Left Anterior Forearm - Cleanse with mild unscented soap and water or a wound cleanser - Vinegar soak per dermatology - Apply a ceramide based lotion (Cera-Ve, Vanicream, Cetaphil) - Sprinkle finely crushed Flagyl to wound bed - Primary dressing: apply about 1/3 of a piece of 4x5 Hydrofera Blue to wound - apply Spandage size 6 to secure - Secondary dressing: apply 1/2 5x9 ABD pad; secure with 1/2 of a 4 inch conforming roll gauze and Medipore tape. How to mix vinegar solution: - Use white vinegar (available at most stores) - Mix 1 tablespoon vinegar with one cup water - Use multiple clean pieces of gauze soaked in the solution and place the wet saturated gauze all over the affected areas for 10 minutes. Compression: Spandage should stay on 24/7 unless showering. It may be washed and reused for about a week. Spandigrip can be removed at night and put back on in the morning. It may be washed and reused for about a month. R3's medical record lacked a a signed service plan or a treatment plan with specific instructions to complete wound care. On July 31, 2024, at 1:58 p.m. LALD-A stated he was unaware the physician orders from the wound care clinic on July 11, 2024, were not signed and was unaware signed physician orders were required for the wound care. On August 1, 2024, at 12:25 p.m. clinical nurse	01970			

Minnesota Department of Health

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01970	Continued From page 113 supervisor (CNS)-B stated when R3 was going to the wound care clinic, the dressing changes were completed there and CNS-B completed it once a week. Since R3 stopped going to the wound care clinic, the staff have completed the dressing changes. CNS-B was unaware the orders were not signed. The licensee's undated, 7.20 Medication & Treatment Orders policy indicated prescriber's orders must be obtained for any treatment being provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01970			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of the licensee's three residents (R3, R4, R5) when the licensee required residents to follow certain house rules. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	02290			

Minnesota Department of Health

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02290	Continued From page 114 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: R3 R3 was admitted on August 9, 2022, with diagnoses including traumatic brain injury, diabetes (a disease that affects blood sugar), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), bacterial skin infection, and had a history of drug abuse receiving methadone (a medication used to treat heroin dependence). R3 did not have a signed service plan. R3's unsigned Service Plan printed on July 31, 2024, indicated R3 received R3's Resident Agreement Assisted Living contract was signed by R3 on May 1, 2024. There was a document titled House Rules attached to the contract and was signed by R3 on May 1, 2024. The House Rules included the following statements: - Staff reserves the right to perform a room search at any time it is deemed necessary to ensure the safety and security of everyone. - House curfew is 11 :30 p.m. every night. Doors will be locked at 11:30 p.m. unless approved. - Residents are allowed to have visitors, but the visitors must leave before 10 p.m. - Visitation: Due to the number of residents that are in the house and the size of the house:	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
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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
02290	Continued From page 115 a. Residents must notify staff prior to the visit. b. One visitor at a time, and two or three visitations per week. c. The client is responsible for their visitor, and visitors must sign in. d. Visitors are not permitted to the house if they are under the influence of alcohol or drugs. e. Staff have the right to ask the visitor to leave if necessary. - Repeated violations of these rules would cause termination of the Resident Contract For Assisted Living. I have read and understood the above procedures and have had explained to me. R4 R4 was admitted on August 1, 2021, with diagnoses that included traumatic brain injury, depression, mood disorder. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. On July 31, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A stated although R4 had a signed service plan dated August 1, 2021, it did not accurately reflect R1's current services and LALD-A printed a Service Plan from the electronic record. R4's unsigned Service Plan printed on July 31, 2024, indicated R3 received behavior management, meal assistance, medication administration, and medication set up. R4's Resident Agreement Assisted Living contract was signed by R4 on August 1, 2021. There was a document titled House Rules attached to the contract and was signed by R4 on August 1, 2021. The House Rules included the following statements:	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37183	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER VISION2020 GROUP HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1805 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
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02290	Continued From page 116 - Staff reserves the right to perform a room search at any time it is deemed necessary to ensure the safety and security of everyone. - House curfew is 11 :30 p.m. every night. Doors will be locked at 11:30 p.m. unless approved. - Residents are allowed to have visitors, but the visitors must leave before 10 p.m. - Visitation: Due to the number of residents that are in the house and the size of the house: a. Residents must notify staff prior to the visit. b. One visitor at a time, and two or three visitations per week. c. The client is responsible for their visitor, and visitors must sign in. d. Visitors are not permitted to the house if they are under the influence of alcohol or drugs. e. Staff have the right to ask the visitor to leave if necessary. - Repeated violations of these rules would cause termination of the Resident Contract For Assisted Living. I have read and understood the above procedures and have had explained to me. R5 R5 was admitted on April 14, 2024, with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), schizophrenia (a serious mental health condition that affects how people think, feel and behave), degenerative joint disease, and major depressive disorder. R5 did not have a signed service plan. R5's Service Plan printed on July 31, 2024, indicated R5 received behavior management, meal assistance, medication administration, and	02290			

Minnesota Department of Health

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02290	Continued From page 117 medication set up. R5's Resident Agreement Assisted Living contract was signed by R5 on April 15, 2024. There was a document titled House Rules attached to the contract and was signed by R5 on April 15, 2024. The House Rules included the following statements: - Staff reserves the right to perform a room search at any time it is deemed necessary to ensure the safety and security of everyone. - House curfew is 11 :30 p.m. every night. Doors will be locked at 11:30 p.m. unless approved. - Residents are allowed to have visitors, but the visitors must leave before 10 p.m. - Visitation: Due to the number of residents that are in the house and the size of the house: a. Residents must notify staff prior to the visit. b. One visitor at a time, and two or three visitations per week. c. The client is responsible for their visitor, and visitors must sign in. d. Visitors are not permitted to the house if they are under the influence of alcohol or drugs. e. Staff have the right to ask the visitor to leave if necessary. - Repeated violations of these rules would cause termination of the Resident Contract For Assisted Living. I have read and understood the above procedures and have had explained to me. On July 30, 2024, at 3:40 p.m. licensed assisted living director (LALD)- A stated he was unaware the house rules limited the rights of the residents and the licensee was just trying to ensure the safety of the residents. No further information was provided.	02290			

Minnesota Department of Health

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02290	Continued From page 118 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

Type: Full
Date: 08/01/24
Time: 11:00:00
Report: 1013241056

Food and Beverage Establishment Inspection Report

Page 1

Location:

Vision2020 Group Homes Llc
1805 15th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0038061
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514684729
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

KITCHEN DISH MACHINE SANITIZES WARE WITH HOT WATER. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. DISCUSSED SANITIZER TESTING PROCEDURES.

Comply By: 08/08/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

KITCHEN DISH MACHINE DID NOT WORK. PER STAFF THE MACHINE WILL BE REPAIRED WITHIN A WEEK. WARE WILL BE SANITIZED WITH A LIQUID SANITIZER UNTIL THE DISH MACHINE IS REPAIRED.

Comply By: 08/08/24

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

FOOD DEBRIS BUILD UP WAS INSIDE THE BASEMENT KITCHEN MICROWAVE. DISCUSSED CLEANING PROCEDURES WITH STAFF.

Comply By: 08/01/24

Food and Equipment Temperatures

Type: Full
Date: 08/01/24
Time: 11:00:00
Report: 1013241056
Vision2020 Group Homes Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cheese
Temperature: 41 Degrees Fahrenheit - Location: Main level kitchen refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Main level kitchen refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Main level kitchen refrigerator
Violation Issued: No

Process/Item: Cheese
Temperature: 40 Degrees Fahrenheit - Location: Basement kitchen refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Basement kitchen refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator S. Haag.

The establishment has two residential kitchens and serves food that is prepared that day. The kitchens have wood cabinets, tile floors, painted walls, solid counter tops, and textured painted ceilings.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle. The dish machine was not working during the inspection. Staff sanitize ware with liquid sanitizer. The operator stated the dish machine would be repaired within the week.

Facility's MN CFPM recently left the facility. The operator plans to take a food manager's course and apply for MN CFPM.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

Type: Full
Date: 08/01/24
Time: 11:00:00
Report: 1013241056
Vision2020 Group Homes Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013241056 of 08/01/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Fuad Ahmed
Operator

Signed:_____ 
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us