



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronically Delivered
December 21, 2023

Licensee
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: License Number 412710
Health Facility Identification Number (HFID) 30745
Project Number(s) HL307453581C/7206M, HL307453519C, HL307458544C/5023M,
HL307458545C/5024M, HL307458562C/4965M, HL307458563C/4966M,
HL307458477C/4943M, HL307458386C/4924M, HL307454588C/7784M,
HL307454524C/7706M, HL307457744C/4543M and SL30745016

Dear Licensee:

On December 5, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey and follow-up complaint investigations of your facility to determine correction of orders found on the complaint investigations completed February 16, 2023, March 14, 2023, July 25, 2023 and August 17, 2023 and survey completed April 27, 2023. The follow-up complaint investigations and follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 5, 2023.

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

Furthermore, the follow-up survey determined your agency had not corrected all of the state correction orders issued pursuant to the survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey, found not corrected at the time of the December 5, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 5, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144A.474, subd. 8(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, subd. 12, you have one opportunity to challenge the state correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the MDH within 15 business days of the correction order receipt date.

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11 (g), a home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144A.475, subd 4 and Subd. 7, a request for a hearing must be in writing and received by the MDH within 15 calendar days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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.

If you have any questions, please contact Paul Spencer directly at: 651-223-7329.

Sincerely,

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

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

mpm

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/05/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014			
(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 #HL307451080C/#HL307455804M #HL307451340C/#HL307456024M #SL30745016 On December 4, 2023, through December 5, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for survey #SL30745016-2. Lino Lakes Assisted Living was found to be in compliance with state regulations. No further action required. The following correction order is re-issued, tag identification 0660.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	{0 660}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 660}	Continued From page 1 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test, for three of three employees (registered nurse (RN)-F, an unlicensed caregiver (ULP)-I, and a member of dietary (DA)-J). This had the potential to affect all residents receiving assisted living services, as well as 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 the potential to	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 2 affect a large portion or all of the residents). Finding include: RN-F RN-F was hired on November 20, 2023. RN-F's employee record included a Baseline TB Screening Tool dated November 20, 2023. The record indicated RN-F received his first TST blood test on November 20, 2023, which was read on November 22, 2023, at 4:00 p.m. During an interview on December 5, 2023, at 12:19p.m., RN-F stated he began working in the facility on November 20, 2023. RN-F stated he was in a first-floor office doing orientation on November 20, 2023, and in a second-floor office doing computer training on November 21st and 22nd. Residents reside on both the first and second floors of the facility. ULP-I ULP-I was hired on October 26, 2023. ULP-I's employee record included an undated Baseline TB Screening Tool. ULP-I's record indicated ULP-I received her first TST blood test on October 24, 2023, which was read on October 26, 2023, at 3:56 p.m. ULP-I's timecard indicated ULP-I completed Relias Training on October 24th and 25th and started orientation on October 30, 2023. DA-J DA-J was hired on November 1, 2023 DA-J's employee record included a Baseline TB Screening Tool dated November 28, 2023. The	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 3 record had "Redo" handwritten in the top right corner. The record indicated DA-J received a TST blood test on November 28, 2023, which was read on November 30, 2023, at 1:00 p.m. During an interview on December 4, 2023, at 4:21 p.m., RN-A stated during an audit she completed, she noticed DA-J had missed a second step TST. RN-A stated she removed DA-J from the scheduled and started the TST steps over. RN-A was unable to locate DA-J's original TB documentation. RN-A later submitted DA-J's original TB information. The document indicated DA-J completed a Baseline TB Screening Tool on November 1, 2023, received his first TST blood test on November 1, 2023, which was read on November 3, 2023, at 2:00 p.m. DA-J's timecard indicated DA-J worked on November 22, 23, 24, and 25 before being removed from the schedule and restarting the TST process. During the exit conference on December 5, 2023, at 2:15 p.m., LALD-B indicated staff can do Relias Training at home but there is no way to provide documentation staff completed it at home. The licensee policy 8.16 Tuberculosis Screening, dated August 1, 2021, indicated no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented. The policy further indicated TB screening would consist of two-step Mantoux and results would be kept in the employee medical file.	{0 660}			

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{0 660}	Continued From page 4 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and administered 1-3 weeks after the first one. Baseline TB screening should be documented in the employee's record."	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and 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	{0 680}			

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{0 680}	Continued From page 5 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: No further action required.	{01460}			
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	{01540}			

Minnesota Department of Health

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{01540}	Continued From page 6 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01540}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 7 This MN Requirement is not met as evidenced by: No further action required.	{01640}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 13, 2023

Licensee

Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: Project Number(s) SL30745016

Dear Licensee:

On September 12, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 24, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 24, 2023, found not corrected at the time of the September 12, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - \$500.00
1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on September 12, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on September 12, 2023, we identified the following violation(s):

0110 - Assisted Living Director License Required - 144g.10 Subdivision 1a - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date.

The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer at 651-587-4460.

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

Sincerely,

A handwritten signature in black ink that reads "Paul J. Spencer". The signature is written in a cursive, flowing style.

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 1-800-337-9238

JMD

Minnesota Department of Health

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{0 000}	Initial Comments INITIAL COMMENTS: SL30745016-1 SL30745016-1 On September 11, 2023, through September 12, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 24, 2023, through April 27, 2023. At the time of the survey, there were 84 residents: 82 receiving services under the Assisted Living (with Dementia Care) license. As a result of the revisit, the following orders were reissued and issued. The following correction orders are re-issued for SL30745016-1, tag identification 0680 and 1640. The following correction order issued for #SL30745016-1, tag identification 0110	{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.		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/12/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014		
(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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed assisted living director (LALD), licensed or permitted by the Board of Executives for Long Term Services and Supports, was employed as required. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 11, 2023, at 8:50 a.m., during an entrance conference, the community director (CD)-C stated she was in the process of completing her LALD license and the corporate regional director was acting as the facility LALD. On September 11, 2023, at 1:00 p.m., the Minnesota Department of Health investigator reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated the previous LALD listed for the licensee had an end date of May 20, 2023. A review of the BELTSS website indicated the facility did not have an LALD listed with	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 BELTSS for the facility and did not list the aforementioned corporate regional director. During an interview on September 11, 2023, at 1:45 p.m., regional director (RD)-D stated she was not acting as the facility's listed LALD, nor did she have a LALD license. During an interview on September 11, 2023, at 1:50 p.m., CD-C stated she has a scheduled appointment to be fingerprinted. CD-C stated once fingerprints were completed and received by BELTSS, CD-C would then be able to obtain a permit and continue to study for the LALD exam. CD-C confirmed from May 20, 2023, to the present no LALD assigned to the facility through BELTSS. CD-C stated she does have a mentor lined up and spoke with the potential mentor in July, however, the person is currently not listed as the agent for the facility. CD-C did not provide an explanation as to why the mentor was not onboard at this time. The licensee's Assisted Living Director policy, dated August 1, 2021, indicated the licensee is required to have an Assisted Living Director licensed or permitted by the Board of Executives for Long Term Services and Supports. The licensed or permitted Assisted Living Director will maintain a current and active license or permit with BELTSS. If a director leaves, the facility will replace the director with a licensed or permitted director within 30 days. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			

Minnesota Department of Health

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0 630	Continued From page 3	0 630			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: See other enforcement action for onsite visit on August 17, 2023.	0 630			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 4 compliance with this subdivision. This MN Requirement is not met as evidenced by: See other enforcement action for onsite visit on July 25, 2023.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and document review, the	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 5 licensee failed to develop a written emergency disaster plan (EP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 11, 2023, April 27, 2023, at 9:26 a.m., the EP policy was requested. On September 11, 2023, at 3:30 p.m., the EP policy binder was reviewed the community director (CD)-C who is also a member of the licensee's EP program. The licensee's written emergency disaster plan, not dated, lacked the following required content: -addresses elements of sheltering in place. -updated agreements with temporary relocation sites, and details staff assignments in the event of a disaster or emergency. -have a written policy and procedure regarding missing residents. - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents. - conduct exercises at least twice a year including an annual full-scale exercise that is community based or individual based functional exercise or if facility experiences an actual emergency; and an additional annual exercise that may include a	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 6 full-scale exercise or mock disaster drill or table-top exercise. -procedures for tracking of staff and residents. -policies to address resident information, protect confidentiality, and secure/maintain records. -method for sharing information and medical documentation for residents in the event of an evacuation. -method for sharing information with residents and their families/representatives. -role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the ACT. - collaboration process with local, tribal, regional, State and Federal EPP to maintain integrated response. During an interview on September 11, 2023, at 3:30 p.m., CD-C confirmed the provided emergency binder did not contain all the required information. CD-C stated the binder had been updated, but during review of the binder with CD-C continued to lack all the required documentation. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated a plan would be in place to include all required elements of appendix Z. The plan will include a communication plan focusing on staff, entities under arrangement, other LTC providers, family members, state and federal contacts, and other sources of assistance. Exercises and drills will be conducted, at a minimum, two emergency preparedness drills every 12 months and do not include the required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise, and the second annual exercise will be a second full scale community wide exercise, or a tabletop exercise	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 7 focused on the AL setting. The licensee's Disaster and Emergency Manual, not dated, indicated the purpose of the manual is to prepare and guide the staff and residents in the event of an emergency or disaster.	{0 680}			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: See other enforcement action for onsite visit on July 25, 2023.	{01460}			
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	{01540}			

Minnesota Department of Health

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{01540}	Continued From page 8 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: See other enforcement action for onsite visit on July 25, 2023.	{01540}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 9 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: See other enforcement action for onsite visit on July 25, 2023.	{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 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 record review and interview, the licensee failed to complete a service plan within 14 days of admission for three of three residents	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 10 (R1, R2, and 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 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). R1 R1 admitted to the facility on June 1, 2022, with diagnoses which included dementia and psychosis. During the entrance conference on September 11, 2023, at 8:50 a.m., R1's service plan was requested along with other medical records. A review of R1's medical records included a document titled "Services Delivered." On September 12, 2023 at 8:55 a.m., a second request was made for R1's signed service plan. On September 13, 2023 at 3:19 p.m., a "Master Care Plan" signed on September 13, 2023, was received from the facility. R1's medical record lacked evidence of a signed service plan. R2 R2 admitted to the facility on June 9, 2023, with diagnoses which included dementia and psychotic disturbance. During the entrance conference on September	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 11 11, 2023, at 8:50 a.m., R2's service plan was requested along with other medical records. A review of R2's medical recods included a document titled "Services Delivered." On September 12, 2023 at 8:55 a.m., a second request was made for R2's signed service plan. On September 13, 2023 at 3:19 p.m., a "Master Care Plan" signed on September 13, 2023, was received from the facility. R2's medical record lacked evidence of a signed service plan. R3 R3 admitted to the facility on June 2, 2023, with diagnoses which included cognitive disorder and bipolar disorder. During the entrance conference on September 11, 2023, at 8:50 a.m., R3's service plan was requested along with other medical records. A review of R3's medical recods included a document titled "Services Delivered." On September 12, 2023 at 8:55 a.m., a second request was made for R3's signed service plan. On September 13, 2023 at 3:19 p.m., a "Master Care Plan" signed on September 13, 2023, was received from the facility. R3's medical record lacked evidence of a signed service plan.	{01640}			



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED TO INCLUDE PENALTY AND APPEAL RIGHTS

Electronically Delivered

June 27, 2023

Licensee

Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: Project Number(s) #SL30745016
#HL307451080C/#HL307455804M
#HL307451340C/#HL307456024M

Dear Licensee:

On June 26, 2023, you received results of the April 27, 2023, survey and complaint investigation. The same letter that you received has been amended herein to include the penalty assessment for tag 0510 - Infection Control Program. Please see the penalty information below under "IMPOSITION OF FINES", as well as additional appeal rights under "REQUESTING A HEARING." There have been no other changes. The State Form and Food and Beverage Report you received remain the same and are not included with this letter.

The Minnesota Department of Health (MDH) completed a survey and complaint investigation on April 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey and complaint investigation, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

An equal opportunity employer.

Letter ID: IS7N REVISED

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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.

Lino Lakes Assisted Living

June 27, 2023

Page 4

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Paul G. Spencer". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Paul Spencer, Supervisor

State Rapid Response Team

Email: paul.spencer@state.mn.us

Telephone: 651-201-4222 Fax: 651-215-6894

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 26, 2023

Licensee

Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: Project Number(s) #SL30745016
#HL307451080C/#HL307455804M
#HL307451340C/#HL307456024M

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey and complaint investigation on April 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey and complaint investigation, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

An equal opportunity employer.

Letter ID: IS7N REVISED

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-201-4222 Fax: 651-215-6894
PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014		
(X4) ID PREFIX TAG 0 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments *****ATTENTION***** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL30745016 #HL307451080C/#HL307455804M #HL307451340C/#HL307456024M On April 24, 2023 through April 27, 2023, the Minnesota Department of Health initiated a change in ownership (CHOW) survey along with complaint investigation(s) at the above provider, and the following correction orders are issued. At the time of the survey and complaint investigation, there were 97 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued The following correction orders are issued specifically for #HL307451080C/#HL307455804M, tag	ID PREFIX TAG 0 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	(X5) COMPLETE DATE

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 identification 1620 and 1640. The following correction order is issued specifically for #HL307451340C/#HL307456024, tag identification 2360.	0 000			
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 according to the Minnesota Food Code. This had the potential to affect all 97 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated April 24, 2023.	0 480			

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0 480	Continued From page 2	0 480			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to ensure infection control procedures were followed for six of six residents (R6, unidentified resident (UR)1, UR2, UR3, UR4, UR5)) during mealtime. This had the potential to affect all residents in the dining room at communal mealtimes. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510			

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0 510	Continued From page 3 The findings include: During observation on April 24, 2023, at 5:12 p.m., R6 was touching food on the plate of unidentified resident #1 (UR1) sitting next to her. R6 then pulled UR1's plate over to her and started eating the food off it with her fingers. When staff observed R6 doing this, they took the plate away from R6 and gave it back to UR1, staff did not provide UR1 with a new plate of food. During observation on April 25, 2023, at 8:20 a.m., R6 was touching UR2's silverware and UR2 began to yell at R6. Staff removed R6 from the situation and placed her at another table. Staff failed to give UR2 clean silverware following R6 handling it. During observation on April 25, 2023, at 8:32 a.m., unidentified staff #1 (US1) was observed serving plates to residents with a pair of blue gloves on, touching a chair to pull up next to the table, touching silverware for UR3 and UR4, assisting UR3 and UR4 with eating, touched a lanyard with keys attached, and then had UR3 spit out scrambled eggs into her hand and place them back on her plate. These tasks were completed with the same blue gloves worn throughout the observation. During observation on April 27, 2023, at 8:29 a.m., R6 stood up from her chair, pulled UR5 plate across the table, and started eating UR5's leftovers with her fingers. The surveyor alerted unlicensed personnel (ULP)-G, who was sitting at the same table assisting UR3 and UR4 with eating, to what R6 was doing. ULP-G took the plates and as she stood by the table, R6 reached down and grabbed scrambled eggs off UR3's plate with her fingers and ate them.	0 510			

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0 510	Continued From page 4 During an interview on April 27, 2023, at 10:12 a.m., ULP-G stated she had never seen R6 eat off another resident's plate before and was not aware of any decline with R6 that may be causing this change in behavior. During an interview on April 27, 2023, at 2:06 p.m., RN-B, also the Director of Nursing, stated her expectation were for staff to follow infection control practices and these observations were not good infection control practices. The licensee's 8.09 Hand Washing policy, dated August 1, 2021, indicated hand washing techniques should be used to protect the spread of infection. The policy indicated hand washing would be performed by all employees between tasks and procedures, and after bathroom use, to prevent cross-contaminations. The Center for Disease and Control (CDC's) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings Infection Control CDC, dated November 29, 2022, indicated standard precautions are the basic practices that apply to all patient care and included hand hygiene. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 510			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580			

Minnesota Department of Health

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0 580	Continued From page 5 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities. This had the potential to affect all ninety-seven (97) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at 2:00 p.m., during the entrance conference, the licensee's quality management documentation was requested for review of any quality management activity. On April 25, 2023, at approximately 1 p.m., the Quality management documentation was again requested from the licensee.	0 580			

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0 580	Continued From page 6 On April 26, 2023 at approximately 10 a.m. the quality management documentation was again requested from the licensee. On April 27, 2023, the regional director registered nurse (RDRN)-I confirmed there was no current documentation of quality management activity and no quality management activity had occurred by the licensee. The licensee's policy titled 2.31 Quality management program states "To ensure that a healthy, safe, sanitary and respectful environment is provided for residents, employees and other and to assure that resident care is delivered in a safe and efficient manner, this community has developed and implemented a quality management program." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650			

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0 650	Continued From page 7 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure employee records contained the required content for four of four staff (unlicensed personnel (ULP)-D-, (ULP)-E, (ULP)-J and registered nurse (RN)-B) with employee records reviewed. This had the potential to affect all residents 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, 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: ULP-D ULP-D was hired on November 14, 2022. ULP-D provides services to the residents including medication administration.	0 650			

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0 650	Continued From page 8 During an observation on April 25, 2023, at 8:31 a.m., ULP-D provided transfer assistance using a Hoyer lift for R3. ULP-D returned to the medication cart and proceeded to set up medications for distribution. ULP-D's employee record lacked a dated and signed job description. ULP-E ULP-E was hired on January 24, 2023. ULP-E provides services to the residents including medication administration. During observation on April 25, 2023, at 8:30 a.m., ULP-E was providing medication administration to residents in the memory care unit. During an interview on April 25, 2023 at 09:00 a.m. with ULP-E, she stated she was a lead ULP and trained other ULP's. ULP-E's employee record lacked a dated and signed job description. ULP-J ULP-J was hired on June 1, 2022. ULP-J was terminated on April 11, 2023. ULP-J employee record lacked a document containing her address, no background study, no signed job description, and no training records. RN-B RN-B was hired on October 18, 2022.	0 650			

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0 650	Continued From page 9 RN-B's employee record lacked a dated and signed job description. The licensee's Employee Records 4.05 Policy, not dated, indicated employee records will include a completed employee application, documentation of a completed background study, current signed job description and required training and competency testing records as required. TIME PERIOD TO CORRECT: Twenty-One (21) Days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB)	0 660			

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0 660	Continued From page 10 prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of one unlicensed personnel (ULP-E) with employee records reviewed. This had the potential to effect resident, staff members, 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: ULP-E was hired January 24, 2023, to provide assisted living services for the licensee. ULP-E employee records review showed evidence of a completed tuberculosis (TB) history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) on March 3, 2023. On April 25, 2023, at 8:30 a.m., ULP-E stated she has been working as a lead medication passer since late January. Licensee's Infection Control policy, effective date August 1, states the licensee would screen all employees and volunteers for tuberculosis infection and all employees would receive a	0 660			

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0 660	Continued From page 11 two-step Mantoux prior to staff being exposed to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and document review, the	0 680			

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0 680	Continued From page 12 licensee failed to develop a written emergency disaster plan (EP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 27, 2023, at 7:33 a.m., the EP policy was reviewed with director of maintenance (DM)-F who also serves as person in charge of the licensee's EP policy. The licensee's plan, not dated, lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations. - a thoroughly completed risk assessment; - conduct exercises at least twice a year including an annual full-scale exercise that is community based or individual based functional exercise or if facility experiences an actual emergency; and an additional annual exercise that may include a full-scale exercise or mock disaster drill or table-top exercise; - a description of the population served by the licensee; -procedures for tracking of staff and residents; -policies for sheltering in place;	0 680			

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0 680	Continued From page 13 -policies to address resident information, protect confidentiality, and secure/maintain records; -method for sharing information and medical documentation for residents in the event of an evacuation; -method for sharing information with residents and their families/representatives. -role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the ACT; - collaboration process with local, tribal, regional, State and Federal EPP to maintain integrated response. During an interview on April 27, 2023, at 7:33 a.m., the director of maintenance (DM)-F confirmed the provided emergency guide did not contain all the required information. DM-F stated the binder had been updated when new ownership took over June 1, 2022 but did not know the exact date the plan was reviewed. DM-F stated anything pertaining to medical was nursing's responsibility. During an interview on April 27, 2023, at 10:00 a.m., registered nurse (RN)-B stated a separate emergency binder included resident face sheets and medication records in the event of an emergency. RN-B stated she was not part of the emergency disaster plan process. During an interview on April 27, 2023, at 10:57 a.m., executive director (ED)-A stated DM-F and her had not worked on the EP plan together but had a future date set up. The licensee's Disaster and Emergency Manual, not dated, indicated the purpose of the manual is to prepare and guide the staff and residents in the event of an emergency or disaster.	0 680			

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0 680	Continued From page 14	0 680			
0 780 SS=E	TIME PERIOD FOR CORRECTION: Twenty-One (21) Days 144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate.	0 780			

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0 780	Continued From page 15 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On April 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DM)-F. During the facility tour, survey staff observed the following items: In resident rooms 11 and 10 in the memory care wing, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by DM-F accompanying on the tour. 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	0 800			

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0 800	Continued From page 16 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 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DM)-F. During the facility tour, survey staff observed the following items: In resident unit 129, it was observed that wallpaper was peeled off from the wall at the ceiling and wall transition. In resident unit 128, it was observed that excess material and equipment were stored in the unit.	0 800			

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0 800	Continued From page 17 The room was filled with excess tools, equipment, boxes, household supplies, and building material. The unit was not in good repair in regard to resident health and safety in accordance with maintenance and repair program. In the dining room on the first floor, it was observed that the fire-rated door was heavily damaged, and the core framings were exposed. During the interview, DM-F stated that the facility is planning to replace doors in the entire building. In resident unit 204, it was observed that excess material and personal items were stored in the unit. The room was filled with excess clothes, equipment, boxes, and household supplies. The unit was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program. In the corridor on the second floor, it was observed that the wood handrail return piece was missing, and the handrail corner edge was exposed with a sharp edge. Throughout the building, in many locations, it was observed that the fire extinguisher cabinet door was not latch shut when pushed. The door was twisted and exposing sharp metal edges. DM-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810			

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0 810	Continued From page 18 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to provide required employee training on fire safety and evacuation and failed to complete required employee	0 810			

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0 810	Continued From page 19 evacuation drills. This 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 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on April 26, 2023, at approximately 11:00 a.m., with the Community Director (ED)-A and the Director of Maintenance (DM)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During the interview, ED-A stated that the licensee provided annual training to employees, but not twice per year after the initial hire on the fire safety and evacuation plan, as required by statute. A policy was requested on employee training, and one was provided indicating that the licensee only provides annual training. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 4/25/23 at 8:40 a.m., 3/9/23 at 8:00 a.m. and 11/22/23 at 7:10 a.m. with no	0 810			

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0 810	Continued From page 20 further drills being documented. DM-F verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation and record review, licensee failed to ensure employees received orientation training to the assisted living licensing requirements and regulations for one of six employees (registered nurse [RN]-C) with records reviewed before providing direct care. 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).	01460			

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01460	Continued From page 21 The findings include: Unlicensed personal (ULP-E) was hired on January 24, 2023, to provide direct care services to the licensee's residents. On April 25, 2023 at 7:30 a.m., ULP-E was observed providing direct care services for residents in the memory care unit. ULP-E employee records did contain documentation ULP-E completed orientation to the assisted living facility licensing requirements and regulations on April 14, 2023. This was not before providing assisted living services to residents. A policy titled 1.01 Assisted Living statutes and rules overview acknowledges the rules and requirements for this training according to the statutes in 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01540			

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01540	Continued From page 22 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure employees received the required amount of dementia care training in the required period for one of one employee unlicensed personal (ULP-E) records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living facility with dementia care license. ULP-E was hired on January 24, 2023, to provide direct care services to the licensee's residents. On April 25, 2023, at 7:35 a.m., ULP-E was observed providing direct care services for residents in the memory care unit. During record review, ULP-E employee record did not contain documentation of the required eight	01540			

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01540	Continued From page 23 (8) hours of training on the specific dementia care topics within 80 working hours of ULP-E's hire date. The licensee's 5.03 Dementia Training policy dated August 31, 2021, noted direct care employees of assisted living with dementia care licensed facilities would complete eight hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620			

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01620	Continued From page 24 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 the required comprehensive nursing assessment was completed by a registered nurse (RN) for two of three residents (R5, R9). 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). Findings include: R5 R5 admitted to the facility on June 1, 2022, with a diagnosis of multiple sclerosis, type I Diabetes Mellitus, anxiety, and depression, R5's service plan, reviewed March 29, 2023, indicated R5 received services for showering assistance one time a week, housekeeping, laundry, meals, daily resident checks, and medication administration and management. Review of R5's most recent 90-day comprehensive assessment dated March 28, 2023, indicated the assessment was completed	01620			

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01620	Continued From page 25 by the licensed practice nurse (LPN). R9 R9 was admitted to the facility on June 1, 2022, with diagnoses which included major depressive disorder and panic disorder. R9's medical record lacked evidence any assessments were completed. During interviews on April 27, 2023, at 10:00 a.m. and 1:30 p.m., registered nurse (RN)-B, also the director of nursing, stated only an RN can conduct resident assessments. RN-B stated she was unaware the LPN had completed R5's assessment and did not have an explanation why. RN-B also verified R9 did not have any completed assessment in her record. Policy titled 6.01 Assessments, Reviews & Monitoring, dated August 1, 2021, indicated assessments will be conducted by an RN. This same policy indicated the registered nurse who conducted the assessment will date and sign the assessment.	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	01640			

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01640	Continued From page 26 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to complete a service plan within 14 days of admission for one of one residents (R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). R9 admitted to the facility on June 1, 2022, with diagnoses which included major depressive disorder and panic disorder. R9's medical record lacked evidence of a service plan. During an interview on April 27, 2023, at 1:30 p.m., registered nurse (RN)-B, also the Director of Nursing, verified R9's record did not include a	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 27 service plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities;	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014		
(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
02170	Continued From page 28 (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on record review, and interview, the licensee failed to have a written individual activity plan which reflected the resident's activity preferences and needs and included structured and non-structured activities for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R6's diagnoses included dementia. R6's service plan, dated February 5, 2023, indicated R6 would participate in activities of choice in the community and needed assistance/escort to and from activities. R6's intervention flowsheet for March 2023, indicated R6 had spontaneous activities scheduled for every hour from 8:00 a.m. through 8:00 p.m. each day and included one additional spot for as needed (PRN) signature. Of the 403 scheduled spontaneous activity signature spots, 121 were signed off as being completed. The flowsheet did not indicate what type of spontaneous activities R6 completed on those	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014		
(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
02170	Continued From page 29 121 occasions. R6's assessment, dated April 10, 2023, indicated R6 wandered around the unit throughout the day. R6's activity capabilities were best with one-to-one visits due to her stage of dementia, simple commands and conversations which included yes/no answers. The assessment also indicated R6 was at a risk to be abused by other and should be kept in communal areas with staff, safety checks every two hours, and redirected when wandering near other residents as she did not understand the personal space of others. R6's moments that matter form, completed by her husband, dated April 14, 2023, provided the facility with detailed information regarding R6's background, family life, and personal data. The form is used for memory care specific residents by the facility's activity department to create wonderful moments for the resident and allow the resident to feel they are contributing to their community. The form also allows gathers information for staff to understand the important things in R6's life along with things that may trigger both good, bad, and anxious moods or behaviors. During an interview on April 26, 2023, at 11:25 a.m., life enrichment director (LED)-M, stated the Moments That Matter document is used to determine what activities R6 would be interested in participating in. LED-M stated R6 sit with her for short periods while she is working at her desk, sit by her when she is calling out BINGO numbers, walks with her to make copies, and spends one-to-one time with her when LED-M sees her wandering all over the place. LED-M stated other residents will yell at R6 when she gets in their personal space and R6 will yell back	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER LINO LAKES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 725 TOWN CENTER PARKWAY LINO LAKES, MN 55014			
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02170	Continued From page 30 so staff members take R6 and walk away with her. During an interview on April 27, 2023, at 1:30 p.m., registered nurse (RN)-B, also the Director of Nursing, stated the Moments That Matter document should be referenced in the service plan, but they also will be using the electronic medical record (EMAR) for data collection, which is a newer system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			

Type: Full
Date: 04/24/23
Time: 14:43:53
Report: 1021231112

Food and Beverage Establishment Inspection Report

Page 1

Location:

Lino Lakes Assisted Living Llc
725 Town Center Parkway
Lino Lakes, MN55014
Anoka County, 02

Establishment Info:

ID #: 0039255
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632676183
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B **** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THE FINAL UTENSIL SURFACE TEMPERATURE OF THE MEMORY CARE DISH MACHINE MEASURED 152F. STAFF CAN WASH IN THE DISH MACHINE BUT THEY NEED TO MANUALLY SANITIZE OR THEY CAN BRING ALL THE DISHES/UTENSILS TO THE MAIN KITCHEN. SEE COMMENTS.

Comply By: 04/24/23

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.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN THE MEMORY CARE HIGH TEMPERATURE DISH MACHINE. PROVIDE.

Comply By: 05/01/23

Type: Full
Date: 04/24/23
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Lino Lakes Assisted Living Llc

Food and Beverage Establishment Inspection Report

Page 2

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE MEMORY CARE KITCHEN HANDWASHING SINK AND IN THE MEMORY CARE PREP KITCHEN HANDWASHING SINK. STAFF WILL PLACE PAPER TOWELS. MAINTAIN A SUPPLY OF PAPER TOWELS DURING ALL HOURS OF OPERATION.

Comply By: 04/26/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) ON-SITE. INFORMATION ON HOW TO OBTAIN A CFPM SENT WITH REPORT.

Comply By: 05/24/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE DISH MACHINE MEASURING DEVICE FROM THE MAIN KITCHEN DOES NOT TURN ON. REPLACE THE BATTERY.

Comply By: 04/26/23

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.

INTERIOR CAVITY OF THE MICROWAVE IN THE MEMORY CARE PREP KITCHEN CONTAINS SPLASHING OF DRIED FOOD DEBRIS. STAFF CLEANED AND SANITIZED MICROWAVE DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 04/24/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINK IN THE MEMORY CARE KITCHEN IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 04/26/23

Surface and Equipment Sanitizers

Type: Full
Date: 04/24/23
Time: 14:43:53
Report: 1021231112
Lino Lakes Assisted Living Llc

Food and Beverage Establishment Inspection Report

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Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET, MEMORY CARE
Violation Issued: No

Final Utensil Surface Temp: = at 152 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK DISPENSER
Violation Issued: No

Final Utensil Surface Temp: = at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR, MEMORY CARE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: BEEF AND RICE SOUP - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - WALK-IN COOLER
Violation Issued: No

Process/Item: Cooling
Temperature: 58 Degrees Fahrenheit - Location: SPAGHETTI NOODLES - WALK-IN COOLER, COOLING 2 HOURS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MEATLOAF - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: POTATO SALAD - PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: TUNA SALAD - PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT TOMATO - PREP COOLER
Violation Issued: No

Type: Full
Date: 04/24/23
Time: 14:43:53
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Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: BEEF AND RICE SOUP - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: YOGURT - TURBO AIR UPRIGHT COOLER
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	2	4

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH ASSISTANT CHEF, PATRIVA THOMPSON BROWN, AND HEALTH REGULATION DIVISION NURSE EVALUATORS, JULIE SERBUS AND MAGGIE REGNIER.

CONTINUATION OF MN Rule 4626.0905B
STAFF CAN MANUALLY SANITIZE IN THE SINK COMPARTMENT WITH QUATERNARY AMMONIUM (QUAT) OR THEY WASH AND SANITIZE IN THE MAIN KITCHEN DISH MACHINE. ONCE THE MEMORY CARE DISH MACHINE CAN REACH A FINAL UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F STAFF CAN WASH AND SANITIZE IN DISH MACHINE.

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 1021231112 of 04/24/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

PATRIVA THOMPSON BROWN
ASSISTANT CHEF

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us