Electronically Delivered

August 19, 2024

Licensee
Vikings Home Health Care LLC
11551 Georgia Avenue North
Champlin, MN 55316

RE: Project Number(s) SL34710015

Dear Licensee:

On July 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 25, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

May 22, 2024

Licensee
Vikings Home Health Care LLC
11551 Georgia Avenue North
Champlin, MN 55316

RE: Project Number(s) SL34710015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34710	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKINGS HOME HEALTH CARE LLC	11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34710015-0 On April 22, 2024, through April 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on April 23, 2024, issued for SL34710015, tag identification 0820. On April 29, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	0 620		

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0 620	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of two residents (R1) when the licensee had a reason to believe there was a suspected financial abuse but did not report it to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 620		

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0 620	Continued From page 3 R1 was admitted on July 13, 2020, with diagnoses which included anxiety disorder, schizophrenia, other encephalopathy, alcohol dependance, alcohol use chronic pain, major depressive disorder, and other arthritis. R1's Resident Service Agreement dated April 22, 2024, indicated R1 has a history of being vulnerable to financial exploitation. R1's service agreement indicated R1 was at risk for to be abused physically, verbally, emotionally, financially, and sexually. R1's service agreement also indicated due to difficulty communicating, R1 may not report abuse or neglect. R1's IAPP dated April 8, 2024, indicated R1 was at risk to be abused physically, verbally, emotionally, financially and/or sexually. It also indicated R1 had a history of being vulnerable to financial abuse by others. On April 23, 2024, at 9:00 a.m., housing manger (HM)-B stated R1 usually goes to their family member's (F-H) house every time they get paid. HM-B also stated R1 goes out with 120 dollars and comes back with approximately 30 dollars. When asked what they did with the money, R1 says they bought cigarette but owner (O-G) buys cigarette for R1. On April 23, 2024, at 9:15 a.m., via telephone, O-G stated F-H calls R1 on the 7th of every month about R1's money. O-G stated they overheard F-H on the phone telling R1 to ask for money "tell her [O-G] to Cashapp or Zelle (money transferring applications) it [referring to money]." O-G also stated R1's rent was supposed to be 500 dollars per month, but they reduced the rental rate to 400 dollars so O-G can buy R1 cigarettes with the remaining 100 dollars.	0 620		

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0 620	Continued From page 4 Surveyor inquired to know which rental rate was reflected on their rental agreement and O-G stated the rental rate on the contract was 500 dollars and "I am just being nice." O-G stated F-H finishes using all of R1's money. On April 23, 2024, at 10:00 a.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated they did not report the suspected financial abuse to MAARC because they did not have evidence to back it up. On April 24, 2024, at 8:56a.m., O-G had filed a complaint report to MAARC regarding R1's financial exploitation by F-H and provided the case number to the surveyor during the survey. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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	0 630		

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0 630	Continued From page 5 by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on July 13, 2020, with diagnoses which included anxiety disorder, schizophrenia, other encephalopathy, alcohol dependance, alcohol use chronic pain, major depressive disorder, and other arthritis. R1's Resident Service Agreement dated April 22, 2024, indicated R1 has a history of being vulnerable to financial exploitation. R1's service agreement indicated R1 was at risk for to be abused physically, verbally, emotionally, financially, and sexually. R1's service agreement also indicated due to difficulty communicating, R1 may not report abuse or neglect. R1's IAPP dated April 8, 2024, indicated R1 was at risk to be abused physically, verbally, emotionally, financially and/or sexually. It also indicated R1 had a history of being vulnerable to financial abuse by others and was not at risk to abuse other vulnerable adults. R1's IAPP did not include the required statements of the specific	0 630		

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0 630	Continued From page 6 measures to be taken to minimize the risk of abuse to that person. On April 22, 2024, at 1:17 p.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated "we have an action plan in place, but it is just not on the IAPP." The surveyor inquired to know where they have documented the action plan in R1's file. LALD/RN-D was unable to locate a statement to indicate specific interventions to minimize the risk of abuse. LALD/RN-D stated they will make corrections on the IAPP to include action plan to minimize the risk of abuse. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated in compliance with Minnesota Statutes, all assisted living service employees were required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 7 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 20, 2023, to provide direct care services to residents. On April 24, 2024, at 7:35 a.m., the surveyor observed ULP-E perform medication administration.	0 650		

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0 650	Continued From page 8 ULP-E's employee record included a [licensee] Orientation and Training Tracking Form dated November 20, 2023, however, ULP-E's employee record lacked the required documentation for the following training topics: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; - record of 30-day supervision; and - competency evaluations. On April 23, 2024, at 11:28 a.m., ULP-E stated they received training and a competency evaluation upon hire. ULP-E stated they were trained by clinical nurse supervisor (CNS-C) on all of the above-mentioned topics. On April 23, 2024, at 11:31 a.m., CNS-C stated	0 650		

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0 650	Continued From page 9 they trained ULP-E but did not document that the training was given. The licensee's personnel Records policy dated August 1, 2021 read, " 2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 10 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Plan dated August 1, 2021, lacked evidence of the following required content:	0 680		

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	34710	A. BUILDING: _____ B. WING _____	04/25/2024

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0 680	Continued From page 11 - yearly review of the emergency preparedness plan; - role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and - quarterly review of missing resident. On April 23, 2024, at 11:20 a.m., housing manger (HM)-B stated they started working for the licensee in August 2023, and did not get the chance to update the emergency preparedness plan. HM-B stated it will get fixed right away. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the assisted living director and clinical nurse supervisor at least quarterly and changes to the plan will be documented. Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 12 (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in the immediate vicinity of all sleeping rooms in the facility. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 13 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 a facility tour on April 23, 2024, at 9:30 a.m., with licensed assisted living director/registered nurse (LALD/RN)-D, unlicensed personnel (ULP)-E, house manager (HM)-B, it was observed that the smoke alarm on the main level outside resident sleeping rooms 1, 2 and 3 was not in the immediate vicinity of the sleeping rooms. The smoke alarm provided in the immediate vicinity of lower-level resident sleeping room 4 was not interconnected with other smoke alarms in the facility. During the tour, survey staff explained to LALD/RN-D, ULP-E, and HM-B, that all dwelling units are required to be provided with smoke alarms outside of and in the immediate vicinity of sleeping rooms. All smoke alarms are required to be interconnected so that the actuation of one alarm causes all alarms within the dwelling to operate. During the tour, LALD/RN-D, ULP-E, and HM-B, verified the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		

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0 800	Continued From page 14	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on April 23, 2024, at 9:30 a.m., with licensed assisted living director/registered nurse (LALD/RN)-D, unlicensed personnel (ULP)-E, house manager (HM)-B, the surveyor made the following observations of facility hazards and disrepair:	0 800		

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0 800	Continued From page 15 There was a hole in the drywall behind the door in resident room 1. The clothes washer and dryer in the lower level were both plugged into a multi plug extension cord. One major appliance is allowed to be plugged into a relocatable power tag (power strip) with overcurrent protection, or the appliances shall be plugged directly into the electrical outlet without the use of extension cords. The window well in lower-level resident room 4 was 46 inches deep and was not provided with a ladder. Window wells with a depth greater than 44 inches shall be provided with a permanently affixed ladder. The door from the dwelling into the garage was marked with an exit sign. Marked exit doors shall not lead through an intervening space of higher hazard. During the tour, LALD/RN-D, ULP-E, and HM-B, verified these deficient findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 16 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 17 safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D, unlicensed personnel (ULP)-E, and house manager (HM)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP undated, failed to include the following: The location and/or number of resident sleeping rooms was not included in the FSEP. The resident sleeping room numbers were posted on the room doors, but they did not match the numbers on the evacuation map that was posted on each floor level of the facility. The FSEP floor plan indicated exiting through the attached garage. Exits shall not lead through intervening rooms with a higher hazard than the assisted living occupancy. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The policy had not been updated to provide complete actions for	0 810		

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0 810	Continued From page 18 employees to take in the event of a fire or similar emergency specific to the facility. The FSEP did not include procedures for staff to follow in case of relocation. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include unique needs/ evacuation status for each individual resident during evacuation. During an interview on April 23, 2024, at 11:00 a.m., LALD/RN-D, ULP-E, and HM-B, stated that they were unclear of the requirements. Survey staff explained that the policy they provided listed the items that are required to be in the policy, but the policy needs to be modified to be specific to this facility and resident needs. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident, by not providing documentation of any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 19 provide training to employees on the FSEP upon hire and at least twice per year as evident by, not providing documentation of any training provided or training scheduled for a future date for staff. During an interview on April 23, 2024, at 11:00 a.m., LALD/RN-D, ULP-E, and HM-B, stated that records were not available for staff or resident training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation any evacuation drills had been conducted. During an interview on April 23, 2024, at 11:00 a.m., LALD/RN-D, ULP-E, and HM-B, stated that records were not available for evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	0 820		

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0 820	Continued From page 20 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on 4/23/2024, at 9:30 a.m., with licensed assisted living director/registered nurse (LALD/RN)-D, unlicensed personnel (ULP)-E, house manager (HM)-B, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2 and 3. Occupied Resident Rooms Resident sleeping room 2, occupied by R1, emergency escape and rescue clear window opening measurements are 30 1/2 inches wide, 19 3/4 inches in height and 602 square inches in openable area. The window was measured with	0 820		

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0 820	Continued From page 21 LALD/RN-D, ULP-E, HM-B, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. Unoccupied Room Resident sleeping room 1, unoccupied, emergency escape and rescue clear window opening measurements are 30 1/2 inches wide, 19 3/4 inches in height and 602 square inches in openable area. The window was measured with LALD/RN-D, ULP-E, HM-B, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. Resident sleeping room 3, unoccupied, emergency escape and rescue clear window opening measurements are 30 1/2 inches wide, 12 inches in height and 366 square inches in openable area. The window was measured with LALD/RN-D, ULP-E, HM-B, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. It was explained to LALD/RN-D, ULP-E, and HM-B, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by LALD/RN-D, ULP-E, and HM-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for	0 820		

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0 820	Continued From page 22 the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On April 29, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 820		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this	01040		

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01040	Continued From page 23 section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice of an expedited termination of contract to the Office of Ombudsman for Long Term Care (OOLTC) and failed to give adequate notice of 15 days for one former resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's Discharge or Deceased Resident Roster dated April 22, 2024, indicated R2 was admitted to the licensee on July 3, 2023, and discharged from the licensee on February 12, 2024. R2's diagnosis included bipolar disorder, hypertension, gastroesophageal reflux disease (GERD), post-traumatic stress disorder, depression with anxiety, unspecified personal disorder, personal history of noncompliance with medical treatment, presenting hazard to health, type 2 diabetes mellitus, tobacco abuse, diabetic foot infection, diabetic neuropathy, and scoliosis.	01040		

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01040	Continued From page 24 R2's signed service plan dated July 1, 2023, indicated R2 received assistance with ambulation, bathing assistance, dressing, grooming, daily housekeeping, laundry service, symptom management, behavior management, medication administration, meals reminder, and transfer assistance. R2's progress note written by the housing manager (HM)-B on January 31, 2024, at 8:30 a.m., indicated R2 was sent to the hospital for evaluation on January 31, 2024. R2's progress note read, "The client has been very manic, aggressive, violent, and verbally abusive towards staff and residents the past few days. This morning the police was called 2X [twice]. The client physically attacked a worker and chased the worker to her car. The police called an ambulance and took the client to Unity hospital for evaluation." R2's Viking Home Health Care Discharge - Transfer Summary completed by clinical nurse supervisor (CNS)-C on February 12, 2024, indicated R2 was discharged to the hospital on January 31, 2024. R2's record included a Viking Home Health Care Notice of Termination of Assisted Living Contract with an effective termination date of February 29, 2024. The letter indicated the reasons for termination were "not following house rule, threatening, constant accusing, fighting, being violent with staff and residents, not considering verbal warning given previously and not following house rules notice." The letter did not indicate if the termination was expedited termination. On April 23, 2024, at approximately 9:15 a.m.,	01040		

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	34710	A. BUILDING: _____ B. WING _____	04/25/2024

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01040	Continued From page 25 owner (O)-G, via telephone, stated they terminated R2 from the licensee because R2 was giving R1 a hard time. O-G stated R2 gave R1 edible marijuana, R2 made racial comments against R1 and other residents, and called them names. O-G stated family member (F)-H manipulated R2. On April 23, 2024, at approximately 10:06 a.m., CNS-C stated R2 was paranoid, and R2 was chasing people with a knife the day R2 was sent to the hospital. On April 23, 2024, at approximately 10:08 a.m., HM-B stated R2 did not have knife, but R2 was chasing people, R2 called the police, and when police arrived at the facility, R2 told the police that F-H made R2 call the police. On April 23, 2024, at approximately 10:10 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not aware O-G initiated R2's discharge. The surveyor inquired to know if a termination notice was given to the resident prior to termination. HM-B stated R2 was given a verbal notice first, followed by a written notice, and provided the surveyor with the above-mentioned termination notice. HM-B and LALD/RN-D did not know why the notice was dated February 29, 2024, when the discharge-transfer summary completed on February 12, 2024, indicated discharge date of January 31, 2024. LALD/RN-D also stated they did not know they were required to notify the ombudsman. On April 23, 2024, at 10:36 a.m., CNS-C stated emergency relocation form was not provided to R2, and ombudsman was not notified of the relocation. CNS-C stated they were not aware of	01040		

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01040	Continued From page 26 the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify ombudsman if resident stayed out of the facility for more than four days. On April 23, 2024, at 12:46 p.m., R2's family member (F)-I stated the termination was very abrupt. F-I stated they did not get any written or verbal notice prior to R2's hospitalization. F-I stated they were told by O-G that R2 cannot come back to the licensee via telephone, while R2 was still in the hospital, therefore R2 was homeless. On April 24, 2024, at 8:56 a.m., O-G via telephone, stated a written and a verbal notice was provided prior to termination. The surveyor inquired to know why the written notice was dated February 29, 2024, when the discharge transfer summary completed on February 12, 2024, indicated a discharge date of January 31, 2024. O-G stated, "I apologize." On April 22, 2024, at approximately 10:30 a.m., LALD-A and CNS-C stated they were familiar with current assisted living laws and regulations. The licensee's Discharge and Transfer of Resident policy dated August 1, 2021, read, "Procedure: Facility-Initiated Termination 4. Prior to issuing a notice of termination, [licensee] shall schedule and participate in a pretermination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reason(s) for the proposed termination and identify/offer reasonable accommodations, modifications or other alternatives to avoid the termination. a. A written notice for the meeting will be provided to the resident and the resident's	01040		

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01040	Continued From page 27 representatives at least five (5) business days in advance and shall include the following information: i. A proposed date, time and location for the meeting ii. A detailed explanation of the reason or reasons for the proposed termination iii. A list of facility individuals who will attend the meeting iv. An explanation that the resident may invite family members, relevant health professionals, a representative from the Office of Ombudsman for Long-Term Care and other individuals of the resident's choosing to attend the meeting v. Contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities with a statement that the ombudsman offices provide advocacy services for residents vi. The name and contact information for an individual from the facility for the resident to contact about the meeting or to request an accommodation vii. Notice that attendees at the meeting may request reasonable accommodations for communication or language viii. Notice of the right to appeal the decision 21. A written notice of an expedited contract termination will be issued to the resident, the resident's legal representative and the resident's designated representative at least 15 days before the effective date of the termination." No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01040		

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01060	Continued From page 28	01060		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 29 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's Discharge or Deceased Resident Roster dated April 22, 2024, indicated R2 was admitted to the licensee on July 3, 2023, and discharged from the licensee on February 12, 2024. R2's diagnosis included bipolar disorder, hypertension, gastroesophageal reflux disease (GERD), post-traumatic stress disorder, depression with anxiety, unspecified personal disorder, personal history of noncompliance with medical treatment, presenting hazard to health, type 2 diabetes mellitus, tobacco abuse, diabetic foot infection, diabetic neuropathy, and scoliosis.	01060		

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01060	Continued From page 30 R2's signed service plan dated July 1, 2023, indicated R2 received assistance with ambulation, bathing assistance, dressing, grooming, daily housekeeping, laundry service, symptom management, behavior management, medication administration, meals reminder, and transfer assistance. R2's progress note written on January 31, 2024, by housing manger (HM-B) and clinical nurse supervisor (CNS)-C indicated R2 was admited to a mental health unit on January 31, 2024. R2's Viking Home Health Care Discharge - Transfer Summary completed by clinical nurse supervisor (CNS)-C on February 12, 2024, indicated R2 was discharged to the hospital on January 31, 2024. On April 23, 2024, at 12:46 p.m., R2's family member (F)-I stated the termination was very abrupt. F-I stated they did not get any written or verbal notice prior to R2's hospitalization. F-I stated they were told by O-G that R2 cannot come back to the licensee via telephone, while R2 was still in the hospital, therefore R2 was homeless. R2's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;	01060		

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01060	Continued From page 31 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On April 23, 2024, at 10:36 a.m., CNS-C stated emergency relocation form was not provided to R2 and ombudsman was not notified of the relocation. CNS-C stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify ombudsman if resident stayed out of the facility for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790		

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01790	Continued From page 32 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was	01790		

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01790	Continued From page 33 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of two employees (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 20, 2023, to provide direct care services to residents. On April 24, 2024, at 7:35 a.m., the surveyor observed ULP-E perform medication administration. ULP-E's employee record lacked evidence they received training and deemed competent for	01790		

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01790	Continued From page 34 unplanned time away when the RN is not available. On April 23, 2024, at 7:50 a.m., ULP-E stated R1 was on leave of absence. The surveyor inquired to know if R1 took their medication with when they left and who dispensed it. ULP-E stated R1 went home with their medication, and they did dispense it. ULP-E also stated they dispensed medication for residents when they had to leave the facility unexpectedly. ULP-E took out a plastic bag from kitchen drawer and demonstrated how they packed medications, labeled, and gave them to the resident who was going away. ULP-E stated they received training on how to dispense medication for leave of absence by clinical nurse supervisor (CNS)-C. On April 23, 2024, at 11:31a.m., CNS-C and licensed assisted living director/registered nurse (LALD/RN-D) stated they were not aware of the requirement to developed training and competencies for ULPs providing medications to residents for unplanned time away and had not provided training for unplanned time away medication administration to any ULPs. On April 22, 2024, at approximately 10:30 a.m., LALD-A and CNS-C stated they were familiar with current assisted living laws and regulations. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated, for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident representative medications in the amounts and doses need for the length of the anticipated absence, not to	01790		

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01790	Continued From page 35 exceed seven days. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on July 13, 2020, with diagnoses which included anxiety disorder, schizophrenia, other encephalopathy, alcohol	01880		

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01880	Continued From page 36 dependance, alcohol use chronic pain, major depressive disorder, and other arthritis. R1's signed service plan dated October 10, 2021, indicated R1 received assistance with ambulation, bathing assistance, dressing, grooming, daily housekeeping, laundry service, symptom management, behavior management, medication administration, meals reminder, and transfer assistance. On April 24, 2024, at 9:35 a.m., the surveyor observed unlicensed personnel (ULP)-E perform medication administration for R1. ULP-E checked Rtask (electronic medical record), clicked the boxes next all medications to indicate prepared, then opened the pill box slot for Wednesday morning and dumped two pills into a cup. The surveyor observed an order for diclofenac gel 1% apply two grams topically to skin four times a day, in Rtask. ULP-E attempted to administer the pills without getting the diclofenac. The surveyor asked ULP-E where the diclofenac gel was. ULP-E showed surveyor the medication cup and said it was all in the cup. Surveyor pointed to diclofenac order in Rtask and inquired to know how they administer the medication. ULP-E stated, "I give it to her by mouth everything is oral." R1 stated "I get the diclofenac once a day after shower, I rub it on myself too four times a day. I keep it in my room." Then ULP-E stated the cream used to be kept in the cabinet, but R1 wanted to keep it in their room, and clinical nurse supervisor (CNS)-C said it was ok to keep it in their room. On April 24, 2024, at 9:53 a.m., R1 took diclofenac gel 1% out of their purse and showed it to the surveyor and stated they keep the cream in their purse.	01880		

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01880	Continued From page 37 On April 24, 2024, at 10:24 a.m., CNS-C stated all medications were stored in a locked cabinet. The surveyor asked if residents could self-administer medication. CNS-C stated not unless it is a cream. CNS-C stated R1 can self-administer diclofenac gel. Surveyor inquired to know if there was a self-administration medication form completed for R1. CNS-C stated no, housing manger (HM-B) stated yes, but was unable to provide the form to the surveyor. The licensee's 7.11 Medication Storage policy dated August 1, 2021, read, "Policy Statement: When [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34710	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKINGS HOME HEALTH CARE LLC	11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02290	Continued From page 38 review, the licensee included language which limited the rights of one of one discharged resident (R2) when not following the rules became a reason for R2's termination. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Discharge or Deceased Resident Roster dated April 22, 2024, indicated R2 was admitted to the licensee on July 3, 2023, and discharged from the licensee on February 12, 2024. R2's diagnosis included bipolar disorder, hypertension, gastroesophageal reflux disease (GERD), post-traumatic stress disorder, depression with anxiety, unspecified personal disorder, personal history of noncompliance with medical treatment, presenting hazard to health, type 2 diabetes mellitus, tobacco abuse, diabetic foot infection, diabetic neuropathy, and scoliosis. R2's signed service plan dated July 1, 2023, indicated R2 received assistance with ambulation, bathing assistance, dressing, grooming, daily housekeeping, laundry service, symptom management, behavior management, medication administration, meals reminder, and transfer assistance.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34710	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02290	Continued From page 39 R2's record included an untitled document signed by R2 on January 26, 2023, that read "Don't interfere with other residents [sic] business keep your closet neat (use laundry baskets for all dirty clothes) (use trash basket for trash) keep the bathroom tidy after use, and be responsible and respectful. Threats or any acts of violence toward staff or other residents of a group home will not be tolerated and will result in termination. Swearing and vulgar language will not be tolerated in any part of [licensee] or while in the presence of staff or other residents. [Licensee] residents are encouraged to be positive at all times. When a question or problem arises, please go one on one to resolve the issue and then ask for assistance if that does NOT resolve the issue. Don't give or borrow money, no resident of [licensee] is allowed to borrow or loan money to other residents. Taking medication and eating is restricted to Only Dining Area No walking around naked, Residents must be fully clothed and also expected to maintain good hygiene and personal cleanliness. Please also note that this also includes taking a showers [sic] as directed by staff." R2's record included a [licensee] Notice of Termination of Assisted Living Contract with an effective termination date of February 29, 2024. The letter indicated reasons for termination were "not following house rule, threatening, constant accusing, fighting, being violent with staff and residents, not considering verbal warning given previously and not following house rules notice." On April 23, 2024, at approximately 9:15 a.m., owner (O)-G, via telephone, stated they terminated R2 from the licensee because R2 was	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34710	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIKINGS HOME HEALTH CARE LLC	11551 GEORGIA AVENUE NORTH CHAMPLIN, MN 55316

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02290	Continued From page 40 giving R1 a hard time. O-G stated R2 gave R1 edible marijuana, R2 made racial comments against R1 and other residents, and called them names. O-G stated family member (F)-H manipulated R2. On April 23, 2024, at approximately 10:10 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were not aware O-G initiated R2's discharge. On April 23, 2024, at 10:18 a.m., LALD/RN-D agreed the untitled document mentioned above was against residents' right. LALD/RN-D stated, "the wording was not right, it should be encouraged instead of do not do this, do not do that. I was not aware of that notice." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *04/23/24*
Time: 14:25:59
Report: 8087241114

Food and Beverage Establishment Inspection Report

Location:

Vikings Home Health Care Llc
11551 Georgia Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:

ID #: 0039221
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634380899
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: -8 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF STATE NURSE EVALUATOR DEE MOSISSA.

FLOORS ARE TILE, CABINETS ARE HARDWOOD AND CEILING IS POPCORN IN TEXTURE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF

CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

MAYTAG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK. RIGHT SIDE IS LABELED HAND WASHING SINK.

INSPECTION REPORT EMAILED TO DEE MOSISSA (STATE NURSE EVALUATOR).

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 8087241114 of 04/23/24.

Certified Food Protection Manager: BATHR-ULDHIN I OMAR

Certification Number: FM117223 Expires: 06/12/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

HANNAH ABTALA
MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us