Electronically Delivered

June 4, 2024

Licensee
Millennium Homes LLC
9307 59th Avenue North
New Hope, MN 55428

RE: Project Number(s) SL36084015

Dear Licensee:

On May 30, 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

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36084	A. BUILDING: _____ B. WING _____	R 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HOMES LLC	9307 59TH AVENUE NORTH NEW HOPE, MN 55428

(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 On May 30, 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for an initial survey SL36084015-0 completed April 22, 20204, to April 25, 2024. Millennium Homes LLC was found to be in substantial compliance with state regulations.	{0 000}		
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: No further action required	{0 115}		
{0 660} SS=D	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	{0 660}		

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{0 660}	Continued From page 1 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: No further action required	{0 660}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 2 (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: No further action required	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	{0 810}		

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{0 810}	Continued From page 3 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: No further action required	{0 810}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required	{01290}		

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{01370}	Continued From page 4	{01370}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}		

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{01370}	Continued From page 5 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required	{01380}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	{01530}		

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{01530}	Continued From page 6 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required	{01530}		
{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	{01620}		

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{01620}	Continued From page 7 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required	{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 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.	{01640}		

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{01640}	Continued From page 8 (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: No further action required	{01640}		

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May 15, 2024

Licensee
Millennium Homes LLC
9307 59th Avenue North
New Hope, MN 55428

RE: Project Number(s) SL36084015

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

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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,

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

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36084015-0 On April 22, 2024, through April 25, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents; 4 receiving services under the provider's Assisted Living license. An immediate correction order was identified on April 22, 2024, issued for SL36084015, tag identification 0820. On April 23, 2024, the immediacy of order 0820 was removed, however noncompliance remains. The scope and level remain unchanged. An amended state form was sent out on June 4, 2024, to remove previously noted "provisional assisted living license" and replaced with	0 000	Minnesota Department of Health is documenting the State Licensing 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.	

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0 000	Continued From page 1 appropriate "assisted living license."	0 000		
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with having a secured unit. This had the potential to affect all 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an assisted living	0 115		

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0 115	Continued From page 2 facility. During the entrance conference on April 22, 2024, at approximately 10:30 a.m., manager (M)-A stated there was a lock on the front door that only one resident was able to use. M-A stated the lock had been installed following a recent elopement incident. On April 22, 2024, at approximately 1:45 p.m., surveyor observed locking mechanism on front door that was secured to doorframe. A hinged metal plate folded over to edge of door and locked into place, preventing the door from being opened. M-A demonstrated use of locking mechanism on front door and stated only one resident knew how to disable the lock. M-A stated the other residents were not shown how to unlock door to prevent them from wandering. Licensee's undated Current Resident Roster: State Evaluations forms indicated two of the four residents residing at the facility had a primary diagnosis of dementia. On April 23, 2024, at approximately 1:50 p.m., owner (O)-F stated they would like to change their license to assisted living with dementia care but were unsure of the licensing requirements or how to initiate the license change. O-F stated they would remove the locking mechanism from the front door and would install a door alarm to alert staff when the door was opened. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 115		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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0 660	Continued From page 3	0 660		
0 660 SS=D	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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB testing for one of two employees (manager (M)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 660		

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0 660	Continued From page 4 The licensee's Facility TB Risk Assessment form dated July 11, 2023, identified the facility as a low risk for transmission and listed clinical nurse supervisor (CNS)-C as responsible for maintaining TB records. M-A was hired on September 30, 2023, and began providing assisted living services. M-A's employee record contained a TB history and symptom screen performed by a registered nurse on September 20, 2023. M-A's employee record also contained a tuberculin skin test (TST) given September 25, 2023, and read with a negative result on September 27, 2023. M-A's employee record lacked evidence of a second TST. On April 23, 2024, at approximately 11:30 a.m., licensed assisted living director (LALD)-B stated they were unaware a second TST was required. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) updated June 2023, indicated baseline TB screening includes: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of Mycobacterium tuberculosis by administering either a two-step TST or a single TB blood test. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk	0 660		

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0 660	Continued From page 5 assessment. The guidelines also indicated an employee may begin working with patients 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. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated "[licensee] will observe the recommended precautions related to TB prevention as identified by the CDC and Minnesota Department of Health (MDH). The precautions include the following elements: -risk assessment; -TB screening; and -staff education." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 6 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. During the tour, survey staff observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance inspections had been performed by certified service personnel in the past year. 2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or	0 790		

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0 790	Continued From page 7 operation. 3. One fire extinguisher was not mounted and stored on a ledge at the top of the stairs to the basement. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and M-A, it was verified that fire extinguisher inspections had not been completed and one fire extinguisher was not properly installed. LALD-B and M-A stated a fire extinguisher servicing company had already been contacted to add the New Hope location to the annual maintenance inspection schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including 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 provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 8 with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. During the tour, survey staff observed the following: 1. The front door of the home was designated as an exit on the floor plan. A thumb-turn deadbolt lock and hinge flip-style lock were installed on the front door. Egress doors must release from the latched position in one operation. 2. The door leading into the attached garage from the home was designated as an exit on the floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. 3. There was a water puddle on the basement floor near the clothes washing machine and a water stain on the ceiling around the smoke alarm in the upstairs hallway. Leaking water and moisture provide an environment for mold and mildew growth which can negatively affect the indoor air quality of the home. During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and M-A, it was stated that the flip-style	0 800		

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0 800	Continued From page 9 lock would be removed, and the floor plan revised to remove the exit leading into the garage. LALD-B and M-A stated a plumber and roofing company had already been contacted to review the moisture concerns observed in the home. 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; (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	0 810		

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0 810	Continued From page 10 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to meet the required evacuation drill frequency. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills at a frequency of twice per year per shift with at least one evacuation drill every other month as evident by a review of the completed fire drill reports. Two fire drills were recorded in 2022, two fire drills were recorded in 2023, and one fire drill was	0 810		

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0 810	Continued From page 11 recorded in 2024. During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and house manager (M)-A, it was verified that the licensee had not met the evacuation drill frequency requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must 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 a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect one resident and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 820		

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0 820	Continued From page 12 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. The egress windows in resident bedrooms were opened and measured. The egress window in bedroom 3, occupied by R3, did not meet the minimum requirement for opening width. The egress window in bedroom 3 measured 18.5 inches in width, and 36 inches in height, with a total clear openable area of 666 inches. The egress window in bedroom 3 did not meet the minimum of at least 20 inches in width. One window in each resident bedroom must meet the minimum window opening size of 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). During the facility tour interview on April 22, 2024, M-A verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate On April 23, 2024, the immediacy of order 0820 was removed, however noncompliance remains. The scope and level remain unchanged.	0 820		

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01290	Continued From page 13	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for two of two employees (manager (M)-A, 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 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: M-A	01290		

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01290	Continued From page 14 M-A was hired on September 30, 2023, and began providing assisted living services. M-A's employee record contained a background study dated September 28, 2020, and was affiliated with licensee's former comprehensive license. M-A's employee record also contained evidence that M-A had initiated a background study on September 20, 2023, under a separate facility owned by the same company. The Final Registry Results form dated September 20, 2023, indicated fingerprinting had not been completed as part of the study. M-A's employee record lacked a completed background study affiliated with licensee's current identification under the assisted living license. ULP-E ULP-E was hired on August 1, 2021, and began providing assisted living services. The Department of Health Services (DHS) Net Study 2.0 roster dated April 30, 2024, at 9:50 a.m., indicated ULP-E's background study was completed January 4, 2022, under the COVID-19 study exceptions and had expired on December 31, 2022. ULP-E's employee record lacked a completed background study affiliated with licensee's current identification under the assisted living license. On April 23, 2024, at 11:15 a.m., licensed assisted living director (LALD)-B stated they had not affiliated M-A's background study with the current HFID as both facilities are owned by the same company. LALD-B also stated they were unaware ULP-E's background study had expired.	01290		

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01290	Continued From page 15 The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records would contain results of background studies. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving	01370		

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01370	Continued From page 16 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency testing was completed for two of two employees (manager (M)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued 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: M-A M-A was hired on September 20, 2023, and began providing assisted living services. On April 23, 2024, at 7:00 a.m., M-A was observed providing direct care services to residents. M-A's employee record lacked the following	01370		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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01370	Continued From page 17 documentation of required competency testing to be completed by a registered nurse (RN): -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne pathogens; -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) dressing and assisting with toileting; -medication, exercise, and treatment reminders; -communication skills that include preserving the dignity of the resident and showing respect for the residents and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. ULP-D ULP-D was hired on June 20, 2023, and began providing assisted living services. ULP-D's employee file lacked the following documentation of required competency testing to be completed by a RN: - 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) dressing and assisting with toileting; -medication, exercise, and treatment reminders; and -preparation of modified diets as ordered by a licensed health professional.	01370		

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01370	Continued From page 18 On April 23, 2024, at approximately 7:00 a.m., M-A stated training had been provided by completing computer modules and in-person training was provided by clinical nurse specialist (CNS)-C. On April 23, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-B and CNS-C stated training was documented on a supervisory visit form, and they did not utilize a competency checklist that included all required elements of competency training. CNS-C stated they were unaware of all required elements of competency training and used the supervisory visit form as a training guide. The licensee's Staff Competency policy dated August 1, 2021, indicated: "3. Training and competency evaluations of ULP's include the following: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, and	01370		

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01370	Continued From page 19 preparation of modified diets as ordered by a licensed health professional, food safety, and assistance with eating j) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family k) awareness of confidentiality and privacy l) Understanding appropriate boundaries between staff and residents and the resident's family m) Procedures to use in handling various emergency situations n) Awareness of commonly used health technology equipment and assistive devices." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 20 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency testing was completed in all required areas for two of two employees (manager (M)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: M-A M-A was hired on September 20, 2023, and began providing assisted living services. On April 23, 2024, at approximately 7:00 a.m., the surveyor observed M-A providing direct care to facility residents. M-A's employee record lacked the following documentation of required competency testing to be completed by a registered nurse (RN): -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and	01380		

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01380	Continued From page 21 developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning (ROM). ULP-D UKP-D was hired on June 20, 2023, and began providing assisted living services. ULP-D's employee file lacked the following documentation of required competency testing to be completed by a RN: -reading and recording temperature, pulse, and respirations of the resident; and -range of motion and positioning. On April 23, 2024, at approximately 7:00 a.m., M-A stated training had been provided by completing computer modules and in-person training was provided by clinical nurse specialist (CNS)-C. On April 23, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-B and CNS-C stated training was documented on a supervisory visit form, and they did not utilize a competency checklist that included all required elements of competency training. CNS-C stated they were unaware of all required elements of competency training and used the supervisory visit form as a training guide. The licensee's Staff Competency policy dated August 1, 2021, indicated home health aides will not work for [licensee] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: - basic knowledge of body functioning and changes in body function, injuries, or other reportable changes;	01380		

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01380	Continued From page 22 -reading and recording temperature, pulse, and respirations; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01530		

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01530	Continued From page 23 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required hours of dementia care training was received for one of two employees (manager (M)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: M-A was hired on September 20, 2023, and began providing assisted living services. M-A's employee record contained an EduCare transcript dated April 22, 2024, indicating M-A received one hour and fifteen minutes (1.25 hours) of dementia care training on October 6, 2023. M-A's employee record lacked the required eight (8) hours of initial training required within 160 working hours. On April 23, 2024, at approximately 12:15 p.m., owner (O)-F confirmed M-A's hire date of September 20, 2023, and stated M-A had worked full time since date of hire. O-F stated they thought the requirement was for four (4) hours of	01530		

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01530	Continued From page 24 training as that is what is stated on their orientation checklist. The licensee's Dementia Education policy dated August 1, 2021, indicated the following: -supervisors of direct-care staff must have at least 8 hours of initial dementia education within 120 working hours of employment start date; and -direct care staff must have completed at least 8 hours of initial training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 25 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 August 1, 2021, and began receiving assisted living services. R1's record contained a 90-day Assessment dated January 10, 2024, and a 90-day assessment dated April 15, 2024, indicating a total of 96 days had passed between assessments. On April 23, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-C stated she was aware of the required 90-day timeframe between assessments and was not able to get it completed in time.	01620		

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01620	Continued From page 26 The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 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	01640		

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01640	Continued From page 27 by: Based on interview and record review, the licensee failed to ensure a service plan was finalized no later than fourteen (14) days after the date services are first provided for one of two residents. In addition, the licensee failed to ensure residents' revised service plans were authenticated by the resident or resident's representative 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) 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 admitted on August 1, 2021, and began receiving assisted living services. R1's initial Service Plan was signed October 8, 2021. R1's record lacked a finalized service plan no later than 14 days after the date services were first provided. R1's unsigned service plan dated April 22, 2024, indicated the following services had been added since the last signed service plan: -housekeeping; -laundry; -linen change; -behavior management; -recording of temperature, pulse, and oxygen saturations; and	01640		

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01640	Continued From page 28 -shopping assistance. R1's revised service plan lacked authentication or signature from R1 or R1's representative. On April 23, 2024, at approximately 12:30 p.m., licensed assisted living director (LALD)-B stated they were unaware R1's initial service plan was not finalized in the required time frame. LALD-B also stated they were unaware that authentication or signature was required by resident or resident's representative when services were changed. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would be finalized no later than 14 days after the date services are first provided. The policy also indicated the initial service plan, and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36084015-0 On April 22, 2024, through April 25, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents; 4 receiving services under the provider's provisional Assisted Living license. An immediate correction order was identified on April 22, 2024, issued for SL36084015, tag identification 0820. On April 23, 2024, the immediacy of order 0820 was removed, however noncompliance remains. The scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	0 115		

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0 115	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with having a secured unit. This had the potential to affect all 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an assisted living facility. During the entrance conference on April 22, 2024, at approximately 10:30 a.m., manager (M)-A stated there was a lock on the front door that only one resident was able to use. M-A stated the lock	0 115		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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0 115	Continued From page 2 had been installed following a recent elopement incident. On April 22, 2024, at approximately 1:45 p.m., surveyor observed locking mechanism on front door that was secured to doorframe. A hinged metal plate folded over to edge of door and locked into place, preventing the door from being opened. M-A demonstrated use of locking mechanism on front door and stated only one resident knew how to disable the lock. M-A stated the other residents were not shown how to unlock door to prevent them from wandering. Licensee's undated Current Resident Roster: State Evaluations forms indicated two of the four residents residing at the facility had a primary diagnosis of dementia. On April 23, 2024, at approximately 1:50 p.m., owner (O)-F stated they would like to change their license to assisted living with dementia care but were unsure of the licensing requirements or how to initiate the license change. O-F stated they would remove the locking mechanism from the front door and would install a door alarm to alert staff when the door was opened. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 115		
0 660 SS=D	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	0 660		

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0 660	Continued From page 3 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB testing for one of two employees (manager (M)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 Facility TB Risk Assessment form dated July 11, 2023, identified the facility as a low risk for transmission and listed clinical nurse supervisor (CNS)-C as responsible for maintaining TB records.	0 660		

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0 660	Continued From page 4 M-A was hired on September 30, 2023, and began providing assisted living services. M-A's employee record contained a TB history and symptom screen performed by a registered nurse on September 20, 2023. M-A's employee record also contained a tuberculin skin test (TST) given September 25, 2023, and read with a negative result on September 27, 2023. M-A's employee record lacked evidence of a second TST. On April 23, 2024, at approximately 11:30 a.m., licensed assisted living director (LALD)-B stated they were unaware a second TST was required. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) updated June 2023, indicated baseline TB screening includes: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of Mycobacterium tuberculosis by administering either a two-step TST or a single TB blood test. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients 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	0 660		

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0 660	Continued From page 5 be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated "[licensee] will observe the recommended precautions related to TB prevention as identified by the CDC and Minnesota Department of Health (MDH). The precautions include the following elements: -risk assessment; -TB screening; and -staff education." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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0 790	Continued From page 6 by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. During the tour, survey staff observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance inspections had been performed by certified service personnel in the past year. 2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 3. One fire extinguisher was not mounted and stored on a ledge at the top of the stairs to the basement. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged.	0 790		

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0 790	Continued From page 7 During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and M-A, it was verified that fire extinguisher inspections had not been completed and one fire extinguisher was not properly installed. LALD-B and M-A stated a fire extinguisher servicing company had already been contacted to add the New Hope location to the annual maintenance inspection schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including 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 provide the physical environment in a continuous state of good repair and operation with regard to 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	0 800		

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0 800	Continued From page 8 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 April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. During the tour, survey staff observed the following: 1. The front door of the home was designated as an exit on the floor plan. A thumb-turn deadbolt lock and hinge flip-style lock were installed on the front door. Egress doors must release from the latched position in one operation. 2. The door leading into the attached garage from the home was designated as an exit on the floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. 3. There was a water puddle on the basement floor near the clothes washing machine and a water stain on the ceiling around the smoke alarm in the upstairs hallway. Leaking water and moisture provide an environment for mold and mildew growth which can negatively affect the indoor air quality of the home. During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and M-A, it was stated that the flip-style lock would be removed, and the floor plan revised to remove the exit leading into the garage. LALD-B and M-A stated a plumber and roofing company had already been contacted to review the moisture concerns observed in the home.	0 800		

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0 800	Continued From page 9 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; (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	0 810		

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0 810	Continued From page 10 drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to meet the required evacuation drill frequency. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills at a frequency of twice per year per shift with at least one evacuation drill every other month as evident by a review of the completed fire drill reports. Two fire drills were recorded in 2022, two fire drills were recorded in 2023, and one fire drill was recorded in 2024. During an interview on April 24, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-B and house manager (M)-A, it was verified that the licensee had not met the evacuation drill frequency requirement.	0 810		

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0 810	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must 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 a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect one resident and all 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 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	0 820		

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0 820	Continued From page 12 situation has occurred only occasionally). The findings include: On April 22, 2024, at 11:30 a.m., survey staff toured the home with house manager (M)-A. The egress windows in resident bedrooms were opened and measured. The egress window in bedroom 3, occupied by R3, did not meet the minimum requirement for opening width. The egress window in bedroom 3 measured 18.5 inches in width, and 36 inches in height, with a total clear openable area of 666 inches. The egress window in bedroom 3 did not meet the minimum of at least 20 inches in width. One window in each resident bedroom must meet the minimum window opening size of 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). During the facility tour interview on April 22, 2024, M-A verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate On April 23, 2024, the immediacy of order 0820 was removed, however noncompliance remains. The scope and level remain unchanged.	0 820		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 13 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for two of two employees (manager (M)-A, 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 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: M-A M-A was hired on September 30, 2023, and began providing assisted living services. M-A's employee record contained a background study dated September 28, 2020, and was affiliated with licensee's former comprehensive	01290		

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01290	Continued From page 14 license. M-A's employee record also contained evidence that M-A had initiated a background study on September 20, 2023, under a separate facility owned by the same company. The Final Registry Results form dated September 20, 2023, indicated fingerprinting had not been completed as part of the study. M-A's employee record lacked a completed background study affiliated with licensee's current identification under the assisted living license. ULP-E ULP-E was hired on August 1, 2021, and began providing assisted living services. The Department of Health Services (DHS) Net Study 2.0 roster dated April 30, 2024, at 9:50 a.m., indicated ULP-E's background study was completed January 4, 2022, under the COVID-19 study exceptions and had expired on December 31, 2022. ULP-E's employee record lacked a completed background study affiliated with licensee's current identification under the assisted living license. On April 23, 2024, at 11:15 a.m., licensed assisted living director (LALD)-B stated they had not affiliated M-A's background study with the current HFID as both facilities are owned by the same company. LALD-B also stated they were unaware ULP-E's background study had expired. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records would contain results of background studies. No further information was provided.	01290		

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01290	Continued From page 15 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36084	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HOMES LLC	9307 59TH AVENUE NORTH NEW HOPE, MN 55428

(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
01370	Continued From page 16 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency testing was completed for two of two employees (manager (M)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued 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: M-A M-A was hired on September 20, 2023, and began providing assisted living services. On April 23, 2024, at 7:00 a.m., M-A was observed providing direct care services to residents. M-A's employee record lacked the following documentation of required competency testing to be completed by a registered nurse (RN): -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -basic infection control, including blood-borne	01370		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 17 pathogens; -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) dressing and assisting with toileting; -medication, exercise, and treatment reminders; -communication skills that include preserving the dignity of the resident and showing respect for the residents and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. ULP-D ULP-D was hired on June 20, 2023, and began providing assisted living services. ULP-D's employee file lacked the following documentation of required competency testing to be completed by a RN: - 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) dressing and assisting with toileting; -medication, exercise, and treatment reminders; and -preparation of modified diets as ordered by a licensed health professional. On April 23, 2024, at approximately 7:00 a.m., M-A stated training had been provided by completing computer modules and in-person training was provided by clinical nurse specialist (CNS)-C.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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MILLENNIUM HOMES LLC	9307 59TH AVENUE NORTH NEW HOPE, MN 55428

(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
01370	Continued From page 18 On April 23, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-B and CNS-C stated training was documented on a supervisory visit form, and they did not utilize a competency checklist that included all required elements of competency training. CNS-C stated they were unaware of all required elements of competency training and used the supervisory visit form as a training guide. The licensee's Staff Competency policy dated August 1, 2021, indicated: "3. Training and competency evaluations of ULP's include the following: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, and preparation of modified diets as ordered by a licensed health professional, food safety, and assistance with eating j) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36084	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HOMES LLC	9307 59TH AVENUE NORTH NEW HOPE, MN 55428

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01370	Continued From page 19 cultural background, and family k) awareness of confidentiality and privacy l) Understanding appropriate boundaries between staff and residents and the resident's family m) Procedures to use in handling various emergency situations n) Awareness of commonly used health technology equipment and assistive devices." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01380		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HOMES LLC	9307 59TH AVENUE NORTH NEW HOPE, MN 55428

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01380	Continued From page 20 review, the licensee failed to ensure competency testing was completed in all required areas for two of two employees (manager (M)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: M-A M-A was hired on September 20, 2023, and began providing assisted living services. On April 23, 2024, at approximately 7:00 a.m., the surveyor observed M-A providing direct care to facility residents. M-A's employee record lacked the following documentation of required competency testing to be completed by a registered nurse (RN): -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -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; and - range of motioning and positioning (ROM). ULP-D UKP-D was hired on June 20, 2023, and began	01380		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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01380	Continued From page 21 providing assisted living services. ULP-D's employee file lacked the following documentation of required competency testing to be completed by a RN: -reading and recording temperature, pulse, and respirations of the resident; and -range of motion and positioning. On April 23, 2024, at approximately 7:00 a.m., M-A stated training had been provided by completing computer modules and in-person training was provided by clinical nurse specialist (CNS)-C. On April 23, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-B and CNS-C stated training was documented on a supervisory visit form, and they did not utilize a competency checklist that included all required elements of competency training. CNS-C stated they were unaware of all required elements of competency training and used the supervisory visit form as a training guide. The licensee's Staff Competency policy dated August 1, 2021, indicated home health aides will not work for [licensee] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: - basic knowledge of body functioning and changes in body function, injuries, or other reportable changes; -reading and recording temperature, pulse, and respirations; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning.	01380		

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	36084	A. BUILDING: _____ B. WING _____	04/25/2024

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01380	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the	01530		

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01530	Continued From page 23 licensee failed to ensure the required hours of dementia care training was received for one of two employees (manager (M)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: M-A was hired on September 20, 2023, and began providing assisted living services. M-A's employee record contained an EduCare transcript dated April 22, 2024, indicating M-A received one hour and fifteen minutes (1.25 hours) of dementia care training on October 6, 2023. M-A's employee record lacked the required eight (8) hours of initial training required within 160 working hours. On April 23, 2024, at approximately 12:15 p.m., owner (O)-F confirmed M-A's hire date of September 20, 2023, and stated M-A had worked full time since date of hire. O-F stated they thought the requirement was for four (4) hours of training as that is what is stated on their orientation checklist. The licensee's Dementia Education policy dated August 1, 2021, indicated the following: -supervisors of direct-care staff must have at	01530		

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01530	Continued From page 24 least 8 hours of initial dementia education within 120 working hours of employment start date; and -direct care staff must have completed at least 8 hours of initial training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 August 1, 2021, and began receiving assisted living services. R1's record contained a 90-day Assessment dated January 10, 2024, and a 90-day assessment dated April 15, 2024, indicating a total of 96 days had passed between assessments. On April 23, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-C stated she was aware of the required 90-day timeframe between assessments and was not able to get it completed in time. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 26 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 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 interview and record review, the licensee failed to ensure a service plan was finalized no later than fourteen (14) days after the date services are first provided for one of two residents. In addition, the licensee failed to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 27 ensure residents' revised service plans were authenticated by the resident or resident's representative 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) 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 admitted on August 1, 2021, and began receiving assisted living services. R1's initial Service Plan was signed October 8, 2021. R1's record lacked a finalized service plan no later than 14 days after the date services were first provided. R1's unsigned service plan dated April 22, 2024, indicated the following services had been added since the last signed service plan: -housekeeping; -laundry; -linen change; -behavior management; -recording of temperature, pulse, and oxygen saturations; and -shopping assistance. R1's revised service plan lacked authentication or signature from R1 or R1's representative. On April 23, 2024, at approximately 12:30 p.m.,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 28 licensed assisted living director (LALD)-B stated they were unaware R1's initial service plan was not finalized in the required time frame. LALD-B also stated they were unaware that authentication or signature was required by resident or resident's representative when services were changed. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would be finalized no later than 14 days after the date services are first provided. The policy also indicated the initial service plan, and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *04/22/24*
Time: 10:45:41
Report: 1051241006

Food and Beverage Establishment Inspection Report

Location:
Millennium Homes Llc
9307 59th Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0038579
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128659080
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: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SOUR CREAM
Violation Issued: No

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

THE FACILITY WAS INSPECTED BY KAI YANG (MDH).

MET WITH NURSE SURVEYOR, MICHELLE WINTERS.

DISCUSSED THE FOLLOWING WITH FACILITY STAFF, EMILY SELYUKOV:

EMPLOYEE ILLNESS LOG
FOODBORNE ILLNESSES AND SYMPTOMS
VOMIT CLEAN-UP PROCEURE
HIGHLY SUSCEPTIBLE POPULATION

THE FACILITY SANITIZES KITCHENWARE WITH AN ANSI/NSF 184 DISHWASHER. THE KITCHEN FLOOR IS HARDWOOD, HAS LAMINATE COUNTERTOPS, MDF WOODEN CABINETS, AND POPCORN CEILING TEXTURE.

Type: Full
Date: *04/22/24*
Time: 10:45:41
Report: 1051241006
Millennium Homes Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241006 of 04/22/24.

Certified Food Protection Manager: Ella P. Selyukov

Certification Number: FM62721 Expires: 10/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Emily Selyukov

Signed: _____

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us