Electronically Delivered

August 15, 2024

Licensee
United Assisted Living LLC
1540 Conway Street
Saint Paul, MN 55106

RE: Project Number(s) SL36279015

Dear Licensee:

On July 22, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 28, 2024, follow-up survey and the January 25, 2024, survey were corrected. This follow-up survey verified that the facility is back in 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

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 28, 2024

Licensee
United Assisted Living LLC
1540 Conway Street
Saint Paul, MN 55106

RE: Project Number(s) SL36279015

Dear Licensee:

On March 28, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 25, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 25, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 25, 2024, found not corrected at the time of the March 28, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on March 28, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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

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

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

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

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.

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler, Engineering Manager, at 651-201-3710.

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

Sincerely,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: robert.dehler@state.mn.us
Telephone: 651-201-3710 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36279	A. BUILDING: _____ B. WING _____	R 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED ASSISTED LIVING LLC	1540 CONWAY STREET SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36279015-1 On March 28, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 25, 2024. At the time of the survey, there were 4 residents under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	{0 470}		

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{0 470}	Continued From page 1 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action needed.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	{0 680}		

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{0 680}	Continued From page 2 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each	{0 780}		

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{0 780}	Continued From page 3 separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect the 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 28, 2024, at 12:11 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, smoke alarms	{0 780}		

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{0 780}	Continued From page 4 were tested. Survey staff observed the smoke alarms installed outside the bedrooms were not interconnected with the other smoke alarms in the dwelling unit. The smoke alarms installed in the bedrooms and outside each sleeping area were not all interconnected. During the facility tour interview on March 28, 2024, LALD-A verified the smoke alarms installed outside the bedrooms were not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 780}		
{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	{0 810}		

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{0 810}	Continued From page 5 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training. 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 March 28, 2024, the licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop and maintain the FSEP evident by the following:	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810}	Continued From page 6 Bedroom 4 in the basement was not labeled on the emergency floor plan dated June 28, 2022. The location and number of resident sleeping rooms were not accurately identified. The FSEP included a fire safety policy with a revised date of June 27, 2022. This policy was a template and had not been developed for use at the facility. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP directs employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During the facility tour interview on March 28, 2024, LALD-A verified the FSEP had not been	{0 810}		

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{0 810}	Continued From page 7 revised. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. No training records were provided to support FSEP training had been completed. During the facility tour interview on March 28, 2024, LALD-A verified training records were not available. Record review indicated the licensee failed to provide annual training to residents on fire safety and evacuation as evident by the lack of training documentation. No resident training records to support this training had been completed were provided. During the facility tour interview on March 28, 2024, LALD-A verified resident training records were not available.	{0 810}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}		

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{0 820}	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide one 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 28, 2024, at 12:11 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. The egress windows in resident bedrooms were opened and measured. The window in resident occupied bedroom 4, did not meet the minimum requirements for safe egress. Bedroom 4 - the newly installed window measured 20 inches in height, 28 inches in width, with a total clear openable area of 560 inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum width of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview on March 28, 2024, LALD-A verified the egress window	{0 820}		

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{0 820}	Continued From page 9 measurements and stated the facility would continue to complete a fire watch for this resident bedroom.	{0 820}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}		

Electronically Delivered

February 27, 2024

Licensee
United Assisted Living LLC
1540 Conway Street
Saint Paul, MN 55106

RE: Project Number(s) SL36279015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36279	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED ASSISTED LIVING LLC	1540 CONWAY STREET SAINT PAUL, MN 55106

(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 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: SL36279015-0 On January 22, 2024, through January 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 3 residents, all of whom received services under the provider's Assisted Living Facility license. An immediate correction order was identified on January 22, 2024, issued for SL36279015, tag identification 0820. On January 23, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 1 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to review their staffing plan two times annually to determine if staffing levels met the needs of 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 470		

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0 470	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee converted to an assisted living license August 1, 2021. On January 22, 2024, at 1:00 p.m., the surveyor observed the licensee's staffing plan posted on a door in the kitchen area. The licensee's Facility Staffing Plan, prepared July 13, 2023, by clinical nurse supervisor (CNS)-A, indicated staffing requirements for each shift were: one staff member for each day, evening, and overnight shift. On January 24, 2024, at 10:00 a.m., CNS-B stated they had a consultant come in July who told them they needed a staffing plan and to review the plan. CNS-B stated the first review was done July 13, 2023. CNS-B further stated they would begin reviewing the staffing plan two times per year, as required. The licensee's 2.15 Staffing policy, revised June 27, 2022, indicated the staffing plan would be reviewed at least two times a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 3 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR), dated January 22, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to have a written emergency preparedness plan (EP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 5 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan, last reviewed by the licensee July 15, 2023, lacked documentation of an annual full-scale exercise or individual facility-based functional exercise. On January 24, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee had not conducted an annual full-scale exercise or an individual facility-based functional exercise. The licensee's 1.17 Emergency Preparedness policy dated June 27, 2022, indicated a disaster drill would be conducted at least annually, and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 6 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in two occupied resident bedrooms. 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:	0 780		

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0 780	Continued From page 7 On January 22, 2024, at 1:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. A smoke alarm was not installed in bedroom 5, occupied by R3. The smoke alarm bracket on the ceiling was empty. R3 stated during the facility tour the smoke alarm was taken down because it had been beeping. 2. A smoke alarm was not installed in bedroom 1, occupied by R1. The smoke alarm bracket above the door was empty. During the facility tour interview, LALD-A verified these smoke alarms were missing and stated they were not aware the smoke alarms had been removed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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0 790	Continued From page 8 by: Based on observation and interview, the licensee failed to 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 January 22, 2024, at 1:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. During the facility tour interview, LALD-A stated the fire extinguishers were installed in August 2021. During an interview on January 23, 2024, at 5:30 p.m., clinical nurse supervisor (CNS)-B verified annual maintenance had not been performed on the fire extinguishers and stated they had already contacted the city requesting information on where fire extinguishers could be taken for annual maintenance. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 9	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 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 January 22, 2024, at 1:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. LALD-A was unable to open the storm window installed on the exterior side of the egress window in bedroom 5, occupied by R3. This storm window obstructed the path for egress	0 800		

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0 800	Continued From page 10 escape and could delay exiting in the event of an emergency. During the facility tour interview, LALD-A verified the storm window was not operating properly and stated it would be fixed. 2. An exit sign was posted over the door leading into the garage from the home. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 3. A plastic pot was used for the disposal of burnt cigarettes in the designated smoking area at the front of the building. Containers used for the disposal of burnt cigarettes must be constructed of non-combustible material. LALD-A verified this plastic pot was used for the disposal of burnt cigarettes. During an interview on January 23, 2024, at 5:30 p.m., clinical nurse supervisor (CNS)-B verified an exit sign had been posted over the door leading into the garage. CNS-B stated a new container for the disposal of burnt cigarettes had already been ordered. 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	0 810		

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0 810	Continued From page 11 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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	0 810		

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0 810	Continued From page 12 the residents). The findings include: On January 22 and 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. FIRE SAFETY AND EVACUATION PLAN Bedroom 4 in the basement was not labeled on the emergency floor plan dated June 28, 2022. The location and number of resident sleeping rooms were not accurately identified. The FSEP included a fire safety policy with a revised date of June 27, 2022. This policy was a template and had not been developed for use at the facility. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP directs employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview with survey staff on January	0 810		

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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
0 810	Continued From page 13 23, 2024, at 5:30 p.m., clinical nurse supervisor (CNS)-B verified the FSEP was a template and had not been developed for use at this facility and stated the plan would be revised. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. No training records were provided to support FSEP training had been completed. During an interview with survey staff on January 23, 2024, at 5:30 p.m., CNS-B verified training records were not available and stated employees received training on the FSEP during fire drills and through EduCare, a third-party training provider. CNS-B confirmed the third-party training was not specific to the facility FSEP. Record review indicated the licensee failed to provide annual training to residents on fire safety and evacuation as evident by the lack of training documentation. No resident training records to support this training had been completed were provided. During an interview with survey staff on January 23, 2024, at 5:30 p.m., CNS-B verified resident training records were not available and stated residents received training during fire drills. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills twice per year, per shift with at least one evacuation drill every other month as evident by no fire drill records for March, April, November, and December 2023. Six fire drills were recorded on the 2023 log, these drills were completed in January, February, May, June, August, and October. During an interview on January 23, 2024, at 5:30 p.m., CNS-B verified fire drills were not	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36279	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED ASSISTED LIVING LLC	1540 CONWAY STREET SAINT PAUL, MN 55106

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0 810	Continued From page 14 performed at a frequency of every other month. CNS-B stated the fire drill frequency would be revised. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must 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 compliant egress windows in two occupied and two unoccupied resident bedrooms. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	0 820	This immediate correction order identified on January 22, 2024, has had the immediacy lifted as of January 23, 2024, however non-compliance remained a scope and level of I.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36279	A. BUILDING: _____ B. WING _____	01/25/2024

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0 820	Continued From page 15 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 January 22, 2024, at 1:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. The egress windows in resident bedrooms were opened and measured. The windows in bedrooms 1, 2, 3, and 4, did not meet the minimum requirements for safe egress. Egress window observations: Bedroom 1, occupied by R1 - the sill height of the awning-style window measured 57.5 inches from the floor, the openable area of the window measured 17 inches in height, 39.5 inches in width, and was obstructed by the window opening hardware in the center of the window. Bedroom 2, occupied by R2 - the sill height of the awning-style window measured 56 inches from the floor, the openable area of the window measured 19 inches in height, 37.5 inches in width, and was obstructed by the window opening hardware in the center of the window. Bedroom 3, unoccupied - the sill height of the awning-style window measured 56 inches from the floor, the openable area of the window measured 20 inches in height, 38 inches in width, and was obstructed by the window opening hardware in the center of the window. Bedroom 4, unoccupied - the double hung style window measured 19 inches in height, 32 inches in width, with a total clear openable area of 608	0 820		

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	36279	A. BUILDING: _____ B. WING _____	01/25/2024

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0 820	Continued From page 16 inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum width of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). The maximum sill height for the required escape windows is 52 inches if a step, platform, or bed is secured no more than 44 inches directly between the window. For required escape windows that do not have the required step, platform, or bed secured below it, the maximum sill height is 48". Egress window hardware, including hinges, must not obstruct the clear openable area of the window. During an interview on January 22, 2024, at 2:30 p.m., LALD-A and CNS-B verified the egress windows did not meet the requirements for safe egress. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970		

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0 970	Continued From page 17 contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect the licensees three residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2's record included an Assisted Living Contract, signed on August 1, 2023. The Assisted Living Contract included the following section, indicating a waiver of liability: Indemnification: The licensee "shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On January 23, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated they were not aware the above referenced language was prohibited, and verified the language was present in the contract for all residents. LALD-A further stated they would change the language to meet	0 970		

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0 970	Continued From page 18 requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *01/22/24*
Time: 12:29:32
Report: 8058241021

Food and Beverage Establishment Inspection Report

Location:
United Homes Health Care Llc
United Homes Health Care LLC
1540 Conway Street
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0037888
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3233277906
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.11AB

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

DISH WASHER NOT FIXED TO CABINET - REPAIR

Comply By: 01/31/24

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BURRITO
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: GREEN ONION
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL HOME, NON COMMERCIAL APPLIANCES AND FINISHES
ESTABLISHMENT REP: KIFAH MAALIN
HRD INSPECTOR: TAMMY CARLSON

Type: Full
Date: *01/22/24*
Time: 12:29:32
Report: 8058241021
United Homes Health Care 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 8058241021 of 01/22/24.

Certified Food Protection Manager: KIFAH MAALIN

Certification Number: 108109 Expires: 10/09/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
KIFAH MAALIN
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us