Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 17, 2024

Licensee
Senior Living LLC
7949 Brunswick Avenue North
Brooklyn Park, MN 55443

RE: License Number 416307
Health Facility Identification Number (HFID) 36569
Project Number(s) SL36569015

Dear Licensee:

On December 9, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 22, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 17, 2024.

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

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 20, 2024

Licensee
Senior Living LLC
7949 Burnswick Avenue North
Brooklyn Park, MN 55443

RE: Conditional License Number 416307
Health Facility Identification Number (HFID) 36569
Project Number(s) SL36569015

Dear Licensee:

The Minnesota Department of Health (MDH) completed survey on August 22, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 19, 2024**.

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

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

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

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $12,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration

process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

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

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Senior Living LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Senior Living LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Senior Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Senior Living LLC will contract with an RN to provide consultation concerning all resident(s) to whom Senior Living LLC provides licensed assisted living services under the conditional license. <u>The consultant must have access</u>

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

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Senior Living LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

   i. Progress towards correction of orders;
   ii. Observations of staff delivering assisted living services and the level of competency observed;
   iii. Conversations with residents and family members about satisfaction with assisted living services;
   iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
   v. Overall impressions about the quality of the assisted living services delivered;
   vi. Overall impressions about the dignity with which the residents and their family members are treated;
   vii. Concerns; and any other information requested by the Department or considered important by the RN consultant(s).

e. **Health Facility Construction Permit:** Senior Living LLC, will replace at Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. **Within 21-days from the date of this notice, Senior Living LLC will provide MDH with a copy of the obtained from MNDLI or City with delegated authority.**

f. **General Contractor:** Senior Living LLC must provide the follow to Tim Hanna, Supervisor, at Tim.Hanna@state.mn.us, **within 21-days of the date of this notice:**
I. Name
II. License Number (if required)
III. Contact Information

c. **Egress Window Requirements:** Senior Living LLC will replace at least one window in occupied sleeping rooms #2 and #4, meeting the minimum size requirements:
   i. Must have a minimum openable width of no less than 20 inches
   ii. Must have a minimum openable height of no less than 20 inches
   iii. Must have a total openable area of no less than 648 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.

g. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Senior Living LLC to correct the violations cited during the survey as well as to determine the overall practice of Senior Living LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

h. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

i. **Corrective Action Plan:** Senior Living LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36569015-0 On August 19, 2024, through August 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all receiving services under the provider's Assisted Living license. An immediate correction order was identified on August 19, 2024, issued for SL36569015-0, tag identification 1290. An immediate correction order was identified on August 20, 2024, issued for SL36569015-0, tag identification 0495. An immediate correction order was identified on August 20, 2024, issued for SL36569015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 An immediate correction order was identified on August 21, 2024, issued for SL36569015-0, tag identification 1750.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Licensed assisted living director (LALD)-A had a license effective through October 31, 2024; however, LALD-A's license listed the licensee as the Director of Record with BELTSS, with an	0 110		

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SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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0 110	Continued From page 2 expired "End" date of April 30, 2024. During the entrance conference on August 19, 2024, at 11:30 a.m., LALD-A stated he did not understand why the BELTSS website indicated an end date on the Director of Record for this facility, and stated he would need to check on this. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees;	0 250		

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0 250	Continued From page 3 (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the	0 250		

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0 250	Continued From page 4 potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my	0 250		

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0 250	Continued From page 5 building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be	0 250		

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0 250	Continued From page 6 classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 5, 2021. The licensee had an assisted living license issued on May 1, 2024, with an expiration date of April 30, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented:	0 250		

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0 250	Continued From page 7 (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (5) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (6) orientation to and implementation of the assisted living bill of rights; (7) infection control practices; (8) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (9) medication and treatment management; (10) delegation of tasks by registered nurses or licensed health professionals; (11) supervision of unlicensed personnel	0 250		

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	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 250	Continued From page 8 performing delegated tasks. As a result of this survey, the following orders were issued 0110, 0250, 0470, 0480, 0495, 0580, 0620, 0650, 0660, 0680, 0690, 0700, 0730, 0800, 0810, 0820, 0900, 0910, 0940, 0950, 0970, 1060, 1290, 1440, 1470, 1500, 1530, 1560, 1610, 1620, 1640, 1650, 1710, 1750, 1760, 1770, 1790, 1820, 1880, 1910, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 9 (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 develop and implement a staffing plan for determining the staffing level, that included an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial facility tour with licensed assisted living director (LALD)-A on August 19, 2024, at 12:33 p.m., the surveyor observed an Employee Schedule, dated August 18, 2024, through August 24, 2024, hanging on the side of the refrigerator. The schedule included one staff from 7:00 a.m. to 3:00 p.m., one staff from 3:00 p.m. to 10:00 p.m., and one staff from 10:00 p.m. to 7:00 a.m., each day. The surveyor requested	0 470		

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0 470	Continued From page 10 to review the facility's staffing plan to evaluate the appropriateness of the staffing levels in the facility. On August 22, 2024, at 12:42 p.m., LALD-A stated he was not able to locate the staffing plan. The licensee's Staffing policy, effective August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs, based on an evaluation of the appropriateness of the staffing levels in the facility, and was reviewed at least twice 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 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff had access to a registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. 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	0 495		

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0 495	Continued From page 12 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). This resulted in an immediate correction order issued on August 20, 2024. The findings include: During the entrance conference of August 19, 2024, at 11:25 a.m., licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-D was the primary nurse for the facility. LALD-A said CNS-D had another job but was always available by phone, and came to the facility at least every Monday and Tuesday to set up medications into pill organizers and to complete other duties. LALD-A stated they expected her to come later today. LALD-A stated CNS-D was the only registered nurse for the facility. During observation of a medication administration for R1, on August 19, 2024, at 12:32 p.m., the surveyor noted one evening slot in the weekly pill organizer for Monday, with three yellow capsules, otherwise the pill organizer was empty. Unlicensed personnel (ULP)-B stated CNS-D would be coming to fill the pill organizer. On August 19, 2024, at 3:26 p.m., the surveyor called and left a voice message for CNS-D at the phone number provided by LALD-A, requesting a return call. On August 20, 2024, at 8:35 a.m., ULP-B stated CNS-D did not show up to fill the residents' pill organizer but stated they had an extra week set up for emergencies and were using those today,	0 495		

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0 495	Continued From page 13 and had taken medication from an over-the-counter bottle of pills to complete medication administration for R1. During an interview on August 20, 2024, at 8:40 a.m., LALD-A stated he had been trying to reach CNS-D by telephone and had left messages, but she had not returned any of his calls or text messages. When the surveyor asked what he would do if there was an emergency and he was unable to contact CNS-D, LALD-A stated, "It has never happened before." On August 20, 2024, at 9:48 a.m., the surveyor called and left a voice message for CNS-D, requesting a return call. On August 20, 2024, at 10:39 a.m., CNS-D returned a phone call to the surveyor, and stated, as of last Monday, August 12, 2024, she was no longer working for the facility. During an interview on August 20, 2024, at 11:50 a.m., LALD-A stated, although he reported earlier that CNS-D had not returned any of his calls or text messages, he did speak to CNS-D last evening and she was refusing to come to the facility because the surveyors were here. LALD-A stated CNS-D was still employed here, had not given notice of leaving her position, and said she was just not coming because the survey team was here. On August 20, 2024, at 12:13 p.m., the surveyor received a text message from CNS-D, indicating LALD-A was aware that she had left her position with the facility. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated	0 495		

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0 495	Continued From page 14 August 1, 2022, noted: -availability of licensed (RN/LPN (licensed practical nurse) staff (in addition to an RN who is required to be accessible to the staff 24/7) was blank; and -the registered nurse was available "onsite" "part-time." The licensee's Supervision: Unlicensed Staff policy, dated August 1, 2021, indicated a registered nurse (RN) was available for consultation to staff and was available either in person, by phone or by other means 24 hours/day, 7 days/week. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 580		

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0 580	Continued From page 15 licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A could not recall when the most recent quality management activity was, and stated they did not have a current focus or topic that they were working on at this time, stating "but we would love to do something." A request was made to review documentation of the licensee's quality management activities and LALD-A indicated he would check and provide documentation. On August 22, 2024, at 9:46 a.m., LALD-A indicated he was unable to provide any documentation of ongoing quality management activities. The licensee's Quality Improvement policy, effective August 1, 2021, indicated the licensee had established a quality improvement program based on the organization's size and appropriate to the type of services provided in order to assure	0 580		

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0 580	Continued From page 16 that effective, comprehensive and appropriate plans were operational for all residents within the organization. The policy indicated documentation of Quality Improvement activities was maintained and updated as needed, but not less than annually, would be maintained for at least two years, and would be provided to the Commissioner at the time of survey, investigation, or renewal, as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	0 620		

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0 620	Continued From page 17 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 620		

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0 620	Continued From page 18 review, the licensee failed to immediately report an incident to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R3) who did not return to the facility when expected. 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 August 19, 2024, at 11:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee's current census was four residents, one of which was in the hospital (R6), and one whom was "out with family," and would be returning later that day (R4). The surveyor requested to review all vulnerable adult reports the licensee had made to MAARC in the past six months, to which LALD-A indicated no MAARC reports had been submitted. On August 20, 2024, at 7:50 a.m., unlicensed personnel (ULP)-B stated R4 did not return to the facility the prior evening, as expected. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. During an interview on August 20, 2024, at 8:49	0 620		

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0 620	Continued From page 19 a.m., LALD-A stated R4 left on Sunday, or two days prior, to be with family, and stated family could be actual family, a friend, or a boyfriend. LALD-A stated R4 didn't have any family in the area and stated he was aware of a sister that lived in Florida. LALD-A stated R4 had a boyfriend, but stated he did not know where R4 was or who she was with. LALD-A stated he planned "to wait 48 hours," before reporting her missing, because "that's just what we do." On August 20, 2024, at 9:00 a.m., ULP-B brought R4's cell phone that he stated was in R4's room, downstairs to the area where the surveyors and LALD-A were located, and stated he had someone on the phone wanting to speak to LALD-A. The person on the phone identified himself to LALD-A as R4's brother, stating he gave R4 money on August 19, 2024, in the morning, for transportation back to the facility. LALD-A explained to the caller that R4 did not return to the facility. LALD-A stated again, that he would wait 48 hours to report R4 as missing. LALD-A stated R4 went out of the facility often, but always returned the same day and stated this was unusual for her. When asked at 9:35 a.m., why he was not implementing the missing resident policy, LALD-A stated he was going to "wait a couple more hours," before he called the police. The surveyor reviewed the licensee's Missing Resident policy with LALD-A, and discussed the policy indicated the licensee would immediately investigate any missing resident. LALD-A stated he would implement the policy, and at 9:50 a.m., LALD-A stated he emailed R4's case manager and stated he called 911 to report R4 missing. On August 20, 2024, at 10:07 a.m., ULP-B stated he provided R4's medications to her on the	0 620		

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0 620	Continued From page 20 morning of August 18, 2024, at 11:00 a.m., which included medications for that day and the next morning. Review of the Sign In/Sign Out Sheet located near the front entrance of the facility, indicated R4 signed out of the facility on August 18, 2024, at 11:00 a.m., indicating the destination was "Boyfriend." On August 21, 2024, at 8:15 a.m., ULP-B stated R4 had returned to the facility, and stated R4 reported she was with her family. On August 22, 2024, at 2:32 p.m., LALD-A stated he let the police department know that R4 returned to the facility. LALD-A stated no MAARC report was filed when R4 did not return to the facility when expected and could not be located, and asked the surveyor if he should have. The licensee's Missing Resident policy, effective August 1, 2021, indicated the licensee would immediately investigate any missing resident using an organized approach in order to ensure that if a resident is found to be missing, the appropriate authorities would be notified. The policy directed the Director, Clinical Nurse Supervisor or designee would notify law enforcement, the resident's representative and/or emergency contact, and the resident's case manager, and a vulnerable adult report (MAARC) would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 650	Continued From page 21	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content, including a job description for one of two employees (unlicensed personnel (ULP)-C). 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	0 650		

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0 650	Continued From page 22 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On August 19, 2024, at 11:22 a.m., licensed assisted living director (LALD)-A provided surveyors a current employee list and ULP-C was not listed. The Employee Schedule dated August 11, 2024, through August 17, 2024, noted ULP-C worked four shifts that week. The Employee Schedule dated August 18, 2024, through August 24, 2024, noted ULP-C was scheduled to work three shifts that week. ULP-C was hired on July 15, 2024, to provide assisted living services to licensee's residents. ULP-C's employee record lacked a job description. On August 19, 2024, at 3:12 p.m., LALD-A stated ULP-C was scheduled to work today, and he did not have an employee record for ULP-C yet as he was still organizing his files. The licensee's Personnel Records policy, effective August 1, 2021, indicated a job description is maintained that includes qualifications, responsibilities and identification of supervisors for each job classification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, history and symptom screen, and TB training for two of three employees (unlicensed personnel (ULP)-C, 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) 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	0 660		

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0 660	Continued From page 24 of the residents). The findings include: The licensee's Facility TB Risk Assessment completed on July 26, 2024, read their TB risk level was low and read, "YES" that baseline TB screenings of all health care personnel performed at the time of hire as required. ULP-C ULP-C was hired on July 15, 2024, to provide assisted living services to licensee's residents. ULP-C's employee record lacked TB screening, history and symptom screen, and TB training. On August 19, 2024, at 4:00 p.m., licensed assisted living director (LALD)-A stated he did not have any training records for ULP-C but said the registered nurse had begun training with ULP-C. ULP-E ULP-E was hired on May 1, 2023, to provide assisted living services to licensee's residents. ULP-E's employee record included Baseline TB Screening Tool for Health Care Workers (HCWs) dated May 4, 2023. ULP-E's record lacked evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and TB training upon hire. On August 21, 2024, at 4:04 p.m., LALD-A stated he thought he recalled asking ULP-E to have it done at her primary clinic. After looking at ULP-E's employee record, LALD-A could not locate it and would contact ULP-E to see if it was completed. Upon survey exit, no TB screening was provided to surveyor.	0 660		

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0 660	Continued From page 25 The CDC's document titled Baseline TB Screening and Testing dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. The Minnesota Department of Health (MDH) "Regulations for Tuberculosis Control in Minnesota Health Care Settings," dated July 2013, indicated under HCW (Health Care Worker) education, "TB training is required at time of hire for all HCWs. The content of the training should be appropriate to the job responsibilities and educational or professional background of the HCW." The MDH TB Resources and FAQ's webpage, last updated April 3, 2024, indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. The licensee's Tuberculosis Screening / Prevention policy, effective August 1, 2021, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). In addition, baseline testing was completed upon hire for all direct care providers and anyone who visits the residents including volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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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 (EP) plan with all the required content and failed to evaluate/revise the missing resident policy at least quarterly. This had the potential to affect all four residents receiving services under the assisted living license. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 27 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: -post emergency exit diagrams on each floor; -develop and maintain the EP: -hazard vulnerability assessment; -arrangements/contracts to re-establish utility services; -maintain and annual EP updates: -failure to review Missing Resident Plan quarterly and implement the plan; -process for EP collaboration: -process for cooperation/collaboration with local, tribal, and regional EP; -development of EP policies and procedures; -subsistence needs for staff and patients: -address the following whether evacuated or shelter in place for staff/residents: -food, water, medical supplies, pharmaceutical supplies; -alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal; -develop P/P (policies/procedures) to address system of medical documentation that preserves resident information, protects confidentiality, and	0 680		

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0 680	Continued From page 28 secures/maintains availability of records; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; -communication plan must include: primary and alternative means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; -communication plan must include: method for sharing information and medical documentation for residents under the facility's care, as necessary with other health care providers (HCPs) to maintain continuity of care; -communication plan must include all of the following: means to providing information about the facility's occupancy needs, and it's ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; -communication plan must include all of the following: method for sharing information from the EP, that the facility has determined appropriate, with residents and their families/representatives; -must develop and maintain EP training and testing program: initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role, provide EP training at least annually and maintain documentation of all EP training; -emergency prep testing requirements; -participate in an annual full-scale exercise that is community based OR conduct an annual,	0 680		

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0 680	Continued From page 29 individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On August 19, 2024, at 4:00 p.m., licensed assisted living director (LALD)-A stated the EP plan was stored in the metal file cabinet in the lower-level office which only staff had access. The surveyor requested the hazards identified in the facility's risk assessment and LALD-A stated he would look for it. On August 20, 2024, at 9:00 a.m., LALD-A stated the missing resident policy was reviewed when "it happens," meaning when a resident has gone missing, however, stated "It hasn't happened in a long time." On August 22, 2024, at 9:21 a.m., LALD-A stated he did not have an emergency kit per the EP but had a flashlight somewhere. Surveyor requested documentation of EP exercises completed, and LALD-A explained he completed fire drills with residents and with staff twice a year. He was not familiar with the exercises, so he was told about the Metro Health and Medical Preparedness Coalition website for more information and assistance. The licensee's Emergency Preparedness policy, effective date August 1, 2021, read [licensee] will	0 680		

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0 680	Continued From page 30 have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy, effective August 1, 2021, directed the missing resident procedure would be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records in resident records with current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for two of four residents (R1, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	0 690		

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0 690	Continued From page 31 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Nurse Reassessment Visit, date not legible, identified as 90 day reassessment and signed by former clinical nurse supervisor (CNS)-D, included correction fluid over a previously handwritten date. R1's Nurse Reassessment Visit, dated May 22, 204, identified as 90 day reassessment and post hospital reassessment and signed by former CNS-D, included correction fluid over a previously handwritten date. R1's record lacked legible, permanently recorded, and dated entries. On August 21, 2024, at 9:19 a.m., licensed assisted living director (LALD)-A stated he didn't know why there was correction fluid on the previous date on the reassessments and stated, "[CNS-D] maybe put the wrong date," and stated CNS-D should be answering these questions. R6 R6's start of services was April 12, 2024. R6 had diagnoses including schizophrenia (extreme moods), memory deficits, and general weakness, and received services including medication	0 690		

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0 690	Continued From page 32 set-up, medication administration, dressing, grooming, supervision, housekeeping, and laundry. R6's Resident Evaluation (identified as initial nursing assessment) dated April, 18, 2024, which appeared bolder than the rest of the writing content of the assessment. It appeared the above date was written over a previous date identified as February 11, 2022. The licensee's Clinical Records policy, effective August 1, 2021, indicated each clinical record would include the following: 2. All entries into the clinical record will be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry; and 4. The records will be protected against loss, tampering or unauthorized disclosure and stored in a locked, secured location accessible to employees and contractors authorized to access the records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of	0 700		

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0 700	Continued From page 33 resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure health and medical information were kept private. This had the potential to affect all residents and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, at 11:22 a.m., during entrance conference, licensed assisted living director (LALD)-A stated resident records were both paper and electronic format which they recently began using. The paper records were stored in a lower-level locked office. During facility tour on August 19, 2024, at 12:50 p.m., the surveyors asked to enter the attached garage. LALD-A obtained the key from unlicensed personnel (ULP)-B to open the garage entry door. Upon entry of attached closed two car garage, the surveyors observed multiple boxes and two full binders with medical records belonging to R2 (discharged August 7, 2023) sitting on top of a box in the center of the garage. The surveyors also observed R1's prescription bottle sitting on top of another box. LALD-A stated staff always had access to the garage and he stored discharged resident records in the garage.	0 700		

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0 700	Continued From page 34 Surveyor inquired about personal possessions within the garage, and he stated another discharged resident planned to stop by and pick up their items. During medication administration observation on August 20, 2024, at 12:35 p.m., the surveyor observed a stack of opened manila envelopes full of papers on top of the medication file cabinet in the dining area. ULP-B stated they were medication administration records (MAR) and they had always been left there. On August 22, 2024, at 2:40 p.m., LALD-A stated the manila envelopes were recently put there to find something, but the surveyor stated they had been there since the beginning of the survey then LALD-A stated they should be secured and were accessible to residents and visitors. The licensee's Clinical Records policy, effective August 1, 2021, indicated resident records will be protected against loss, tampering or unauthorized disclosure and stored in a locked, secured location accessible to employees and contractors authorized to access the records. The licensee's Privacy of Protected Health Information policy, effective August 1, 2021, indicated all staff of [licensee] review the Privacy Policies and Procedures during orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 35 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

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0 730	Continued From page 36 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R3), and failed to maintain documentation of medication management for three of three residents (R1, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: DISCHARGE SUMMARY R3 R3's diagnoses included anxiety, substance dependence, fetal alcohol syndrome, obsessive compulsive disorder, attention deficit hyperactivity disorder (ADHD), and depression. R3 began receiving services on February 23, 2024, and was discharged on April 29, 2024, as indicated on the licensee's Discharged or	0 730		

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0 730	Continued From page 37 Deceased Resident Roster: State Evaluations form, completed by licensed assisted living director (LALD)-A on August 19, 2024, when survey was initiated. R3's progress note in RTasks (electronic medical record used by the licensee) indicated on April 29, 2024, R3 had an argument with R1 and R3 hit R1 with a brick on his chest and caused injury. 911 was called and R1 was taken to the hospital. During an interview on August 21, 2024, at 12:36 p.m., LALD-A stated R3 was arrested and taken to jail on April 30, 2024, when R1 decided to press charges. When R3's discharge summary was requested, LALD-A stated he didn't understand what was needed and stated no discharge summary was completed because they weren't sure what would happen to R3, although LALD-A stated they would not be taking R3 back in the facility due to issues involving him, and they had admitted another resident in his place. DOCUMENTATION OF MEDICATION MANAGEMENT During the entrance conference on August 19, 2024, at 11:30 a.m., LALD-A stated the licensee provided medication management services for the residents, including medication set up by the clinical nurse supervisor (CNS)-D and ULPs administered those medications after being trained by CNS-D. R1 R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry.	0 730		

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0 730	Continued From page 38 R4 R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and received services including medication set-up, medication administration, housekeeping, and laundry. On August 22, 2024, at 9:58 a.m., the surveyor requested to review R1's Medication Administration Record (MAR) for August 2023. At 2:54 p.m., LALD-A stated he looked everywhere and he was unable to find the binder that contained all of the residents' MARs from 2023. The licensee's Clinical Records policy, effective August 1, 2021, indicated, following the resident's discharge or termination of services, the resident's clinical record would contain discharge summary and related documentation, and would include documentation of services provided to include medications, treatments, and/or therapies if pertinent. Also included, the licensee would be retain the clinical record for at least five (5) years following the resident's discharge or termination of services. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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0 800	Continued From page 39	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from approximately 12:00 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The following was observed.	0 800		

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0 800	Continued From page 40 EGRESS WINDOWS: The egress window in bedroom 3 had hardware that was not maintained in proper working condition and obstructed the window from opening and closing completely. There was a small tree growing inside the window well of bedroom 3 obstructing the egress window from opening completely. SMOKING AREAS: The two designated smoking areas were not provided with non-combustible ashtrays. The residents were using plastic 5-gallon buckets without any sand or water in the bottom to extinguish the cigarettes. Survey staff explained to LALD-A that a non-combustible ashtray should be provided for resident use and that the discarded cigarette butts were a fire hazard if cigarettes were not completely extinguished before discarding them. GENERAL MAINTENANCE: The smoke alarm in bedroom 3 was chirping, indicating a low battery. The wood trim was missing at the closets in bedrooms 1, 2, and 4 and throughout the basement. The wood wall base was missing throughout the basement. The basement bathroom shower had an unfinished ceiling with large gaps where it met the walls. Water vapor and steam penetration behind the ceiling material could lead to mold growth. The window sill was not installed in the basement bathroom exposing the wall cavity to the humid	0 800		

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0 800	Continued From page 41 environment of the bathroom. The carpet had been removed throughout the basement, but the nailer transition strips were still installed at each doorway threshold. The basement living room window was not finished exposing the wall cavity. There was a hole in the wall outside bedroom 3 and inside bedroom 3 in each of the walls adjacent to the door. There was a leaking pipe above the water heater in the basement utility room. LALD-A stated the pipe had started leaking recently and they were waiting on the maintenance guy to come replace the whole valve. The ramp at the main entrance was missing a guardrail at the landing. LALD-A was using a concrete block as a step to the level of the driveway. LALD-A stated they were temporarily using the concrete block until the steps were built. No timeline for the construction of the steps was provided. On August 20, 2024, at 1:30 p.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 42 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 43 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 August 20, 2024, from approximately 12:00 p.m. to 1:30 p.m., survey staff observed the fire evacuation diagrams did not include the room numbers for each bedroom. On August 20, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 44 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On August 20, 2024, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On August 20, 2024, at 2:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS:	0 810		

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0 810	Continued From page 45 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted monthly, but only completed on the first shift. On August 20, 2024, at 2:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the	0 820	This immediate correction order identified on August 20, 2024, has had the immediacy lifted as of August 21, 2024, however non-compliance remained a	

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0 820	Continued From page 46 minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 August 20, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff asked LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 2: One window measuring 20 1/4 inches clear width, 31 1/2 inches clear height, and 638 square inches total open area. Bedroom 4: One window measuring 20 1/4 inches clear width, 31 1/2 inches clear height, and 638 square inches total open area. The windows in bedrooms 2, 4, did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820	scope and level of H.	

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0 820	Continued From page 47 Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On August 20, 2024, survey staff explained to LALD-A that an immediate correction order was issued for the above findings. LALD-A stated they understood the requirements for egress windows. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the	0 900		

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0 900	Continued From page 48 opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for four of four residents (R1, R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R4, R5, and R6's records lacked evidence of a written contract prior to providing housing and assisted living services. R1 R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Resident Agreement was signed by R1 on August 13, 2023, or two days after R1 began	0 900		

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0 900	Continued From page 49 receiving housing and assisted living services. R4 R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Resident Agreement was signed by R4 on April 20, 2022, or five days after R4 began receiving housing and assisted living services. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and received services including medication set-up, medication administration, housekeeping, and laundry. R5's Resident Agreement was signed by R5 on August 5, 2023, or two days after R5 began receiving housing and assisted living services. R6 R6's start of services was April 12, 2024. R6 had diagnoses including anxiety, and received services including medication set-up, medication administration, housekeeping, and laundry. R6's Resident Agreement was signed by R6 on May 2, 2024, or 20 days after R6 began receiving housing and assisted living services. On August 22, 2024, at 2:16 p.m., licensed assisted living director (LALD)-A stated he wasn't aware he could not offer or provide housing or assisted living services unless a written contract had been executed.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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0 900	Continued From page 50 The licensee's Notifications policy, effective August 1, 2021, indicated, prior to providing housing or assisted living services, the assisted living contract would be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R4, R5, R6). 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	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 910	Continued From page 51 affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: -the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. R1 R1's start of services was August 11, 2023. R1's Resident Agreement, signed by R1 on August 13, 2023, indicated the licensee's Assisted Living License Number; however, lacked the requirements noted above. R4 R4's start of services was April 15, 2022. R4's Resident Agreement, signed by R4 on April 20, 2022, indicated the licensee's Assisted Living License Number; however, lacked the requirements noted above. R5 R5's start of services was August 3, 2023. R5's Resident Agreement, signed by R5 on August 5, 2023, indicated the licensee's Assisted Living License Number; however, lacked the requirements noted above. R6 R6's start of services was April 12, 2024.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 910	Continued From page 52 R6's Resident Agreement, signed by R6 on May 2, 2024, indicated the licensee's Assisted Living License Number; however, lacked the requirements noted above. On August 22, 2024, at 2:16 p.m., licensed assisted living director (LALD)-A stated he wasn't aware that the contract should include the HFID number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;	0 940		

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	36569	A. BUILDING: _____ B. WING _____	08/22/2024

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0 940	Continued From page 53 (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R4, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R4, R5, and R6's Resident Agreement, signed by R1 on August 13, 2023, signed by R4 on April 20, 2022, signed by R5 on August 5, 2023, and signed by R6 on May 2, 2024, lacked the following required content: - whether there is a limit on the number of people	0 940		

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0 940	Continued From page 54 residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the contact information to obtain long-term care consulting services under section 256B.0911. On August 22, 2024, at 2:27 p.m., licensed assisted living director (LALD)-A stated he wasn't aware the above required contents should be included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim	0 950		

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0 950	Continued From page 55 notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four resident's (R1, R4, R5, R6) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. 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	0 950		

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0 950	Continued From page 56 or has potential to affect a large portion or all of the residents). The findings include: R1's start of services was August 11, 2023, and R1's Resident Agreement was signed by R1 on August 13, 2023. R4's start of services was April 15, 2022, and R4's Resident Agreement was signed by R4 on April 20, 2022. R5's start of services was August 3, 2023, and R5's Resident Agreement was signed by R5 on August 5, 2023. R6's start of services was April 12, 2024, and R6's Resident Agreement was signed by R6 on May 2, 2024. R1, R4, R5, and R6's Resident Agreement lacked the following required verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On August 22, 2024, at 2:27 p.m., licensed assisted living director (LALD)-A stated the	0 950		

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0 950	Continued From page 57 contract lacked the verbatim notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all current 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 the potential to affect a large portion or all the residents). The findings include:	0 970		

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0 970	Continued From page 58 The Resident Agreement provided by the licensee, dated May 3, 2021, included the following clauses which indicated the resident would waive the facility's liability for health, safety, or personal property of the resident: -Indemnification, page 16 of 21 of the contract, "Resident will indemnify and hold harmless Landlord, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents;" and -Liability, page 16 of 21 of the contract, "Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Landlord is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third party providers. Landlord may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Room or on Landlord's premises." On August 22, 2024, at 2:27 p.m., licensed assisted living director (LALD)-A stated the contract included the above waiver of liability and he was not aware the contract must not include a	0 970		

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0 970	Continued From page 59 waiver of facility liability for the health and safety or personal property of a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 60 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R6 was admitted to the licensee and began receiving assisted living services on April 12, 2024. R6's diagnoses included schizophrenia (extreme moods), history of drug use, memory deficits, and arthritis. R6's initial Resident Evaluation (registered nurse	01060		

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01060	Continued From page 61 assessment) dated April 18, 2024, assessed R6 required assistance with medication administration, bathing, dressing and grooming, transfers and ambulation. R6's Emergency Relocation Notification printed August 8, 2024, indicated R6 was hospitalized on August 4, 2024. R6 remained at the hospital for the duration of the survey. On August 21, 2024, at 12:15 p.m., licensed assisted living director (LALD)-A stated the notification of emergency relocation was provided to R6's case manager and the ombudsman was notified by email. LALD-A stated he did not provide one directly to the resident because the resident did not have an email and thought providing one to the case manager was sufficient. On August 21, 2024, at 12:26 p.m., LALD-A printed and provided surveyor with an email correspondence between him and the case manager with the attached notification on August 6, 2024, which was two days after R6 was admitted to the hospital. The licensee's Emergency Relocation Notification form printed from an electronic health record (RTasks) on August 8, 2024, indicated the following, "Notification of the emergency relocation is made by the facility to the following entities: Resident, Legal Representative, Designated Representative, and Case Manager (if applicable)." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01290	Continued From page 62	01290		
01290 SS=I	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 background studies were conducted prior to staff providing services, for one of six employees (unlicensed personnel (ULP)-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 19, 2024.	01290		

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01290	Continued From page 63 The findings include: ULP-C had a hire date of July 15, 2024, to provide assisted living services to the licensee's residents. ULP-C's employee record lacked evidence the licensee submitted a background study for ULP-C. During an interview on August 19, 2024, at 3:12 p.m., the surveyor requested ULP-C's employee record from licensed assisted living director (LALD)-A. LALD-A stated he had been working on the paper record for ULP-C, and didn't have it available. Review of the NETStudy 2.0 roster, printed and provided to surveyors on August 19, 2024, lacked ULP-C's name and eligibility information. During an interview on August 19, 2024, at 3:15 p.m., ULP-B stated ULP-C was scheduled to work today at 3:00 p.m., however, was running late. ULP-B stated ULP-C had been working alone with residents for a few weeks. During an interview on August 19, 2024, at 3:21 p.m., LALD-A stated ULP-C didn't work alone "all the time," but "some of the time, he did." When asked if ULP-C had a background study completed, LALD-A stated ULP-C was new and he was working on getting it done. Review of the employee schedule, dated August 11, 2024, through August 17, 2024, ULP-C worked from 3:00 p.m. to 10:00 p.m. on August 12, 2024, August 13, 2024, August 14, 2024, and August 15, 2024, without direct supervision.	01290		

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01290	Continued From page 64 Review of the employee schedule, dated August 18, 2024, through August 24, 2024, ULP-C was scheduled to work from 3:00 p.m. to 10:00 p.m., on August 19, 2024, August 20, 2024, and August 22, 2024. The licensee's Recruitment and Hiring policy, dated August 1, 2021, indicated a criminal background check would be submitted to Minnesota Department of Human services (DHS) following the step-by-step procedure established by DHS. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440		

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01440	Continued From page 65 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for two of two employees (unlicensed personnel (ULP)-B, 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) 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: ULP-B On August 19, 2024, at 11:22 a.m., during entrance conference, licensed assisted living director (LALD)-A provided an employee list which noted ULP-B was hired on October 30, 2021. Later during employee record review, LALD-A stated he made a mistake and ULP-B's hire date was October 30, 2020. On August 19, 2024, through August 22, 2024, it was observed ULP-B provided medication administration, housekeeping, and supervision of residents.	01440		

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01440	Continued From page 66 ULP-E ULP-E was hired on May 1, 2023, to provide assisted living services to licensee's residents. ULP-B and ULP-E's record lacked evidence a RN conducted direct supervision of ULP-B and ULP-E within 30 calendar days of performing delegated tasks or thereafter as needed based on performance. During a telephone interview on August 20, 2024, at 10:40 a.m., former clinical nurse supervisor (CNS)-D stated she was no longer employed by the licensee as of a week ago and stated she was not familiar with ULP-E and had not provided training or competency evaluations for ULP-E. During interview on August 20, 2024, at 11:25 a.m., ULP-E stated CNS-D trained her on medication administration. During interview on August 21, 2024, at 4:46 p.m., ULP-E stated she was trained by LALD-A and CNS-D but could not go into detail on what she was trained on and abruptly ended the call. During interview on August 22, 2024, at 2:40 p.m., ULP-B stated he was trained by a registered nurse from Home Care Consultant and was checked off by a different nurse staffed by licensee. The licensee's Supervision: Unlicensed Staff policy, effective August 1, 2021, indicated direct supervision of [ULPs] performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. The policy also indicated the RN	01440		

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01440	Continued From page 67 will document supervision in the employee's personnel file related to performance management. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 68 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for two of three employees (unlicensed personnel (ULP)-C, and 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) and was issued at a	01470		

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01470	Continued From page 69 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: ULP-C During entrance conference on August 19, 2024, at 11:22 a.m., licensed assisted living director (LALD)-A provided the surveyors with a current employee list and ULP-C was not listed. The Employee Schedule dated August 11, 2024, through August 17, 2024, noted ULP-C worked four shifts that week. The Employee Schedule dated August 18, 2024, through August 24, 2024, noted ULP-C was scheduled to work three shifts that week. ULP-C was hired on July 15, 2024, to provide assisted living services to licensee's residents. ULP-E ULP-E was hired on May 1, 2023, to provide assisted living services to licensee's residents. ULP-C and ULP-E's employee records lacked the following required orientation content: -overview of assisted living statutes; -review of provider's policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -the assisted living bill of rights; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services;	01470		

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01470	Continued From page 70 -review of the types of assisted living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -hearing loss training (optional). During entrance conference on August 19, 2024, at 11:22 a.m., LALD-A stated he set up training which ULPs train with the registered nurse (RN) one on one and train on an online training platform (Educare). He also stated the RN would do competency testing. During interview on August 22, 2024, at 9:21 a.m., LALD-A stated he was unsure when and how often orientation and annual training needed to be completed. The licensee's Personnel Records policy, effective date August 1, 2021, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for [licensee] will be maintained. The personnel record would include orientation training. The licensee's Recruitment and Hiring policy, effective date August 1, 2021, indicated orientation is completed using the Orientation Checklist. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01500	Continued From page 71	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 72 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for one of one employee (unlicensed personnel (ULP)-B). 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 August 19, 2024, at 11:22 a.m., during	01500		

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01500	Continued From page 73 entrance conference, licensed assisted living director (LALD)-A provided an employee list which read ULP-B was hired on October 30, 2021. Later during employee record review, LALD-A stated he made a mistake and ULP-B's hire date was October 30, 2020. On August 19, 2024, through August 22, 2024, it was observed ULP-B provided medication administration, housekeeping, and supervision of residents. ULP-B's employee record lacked annual training to include at least eight hours of training for every 12 months of employment in the following topics: -Infection control techniques; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). During interview on August 22, 2024, at 9:21 a.m., LALD-A stated he was unsure when and how often orientation and annual training needed to be completed. The licensee's Personnel Records policy, effective date August 1, 2021, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for [licensee] will be maintained. The personnel record would include annual and infection control training training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01530	Continued From page 74	01530		
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 licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of two direct care employees (unlicensed personnel (ULP)-E).	01530		

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01530	Continued From page 75 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on May 1, 2023, to provide assisted living services to licensee's residents. ULP-E's employee record included an Educare (online training) transcript that noted ULP-E was "Enrolled" in 42 dementia courses as of May 24, 2023, and July 26, 2024, and 11 dementia courses started were "in progress." The employee record lacked all eight (8) hours of required dementia care training to meet the initial eight hours of dementia training on topics specified under paragraph (b) within 160 working hours of the employment start date. The Employee Schedule dated August 11, 2024, through August 17, 2024, noted ULP-E worked three shifts that week. The Employee Schedule dated August 18, 2024, through August 24, 2024, noted ULP-E was scheduled to work three shifts that week. On August 19, 2024, at 11:22 a.m., during entrance conference, licensed assisted living director (LALD)-A stated he sets up training which ULPs train with the registered nurse (RN) one on one and train on Educare. He also stated the RN	01530		

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01530	Continued From page 76 would do competency testing. On August 21, 2024, at 4:46 p.m., during phone interview, ULP-E stated she was trained by both LALD-A and former clinical nurse supervisor (CNS)-D but could not describe what she was trained on by the nurse and abruptly ended the call. On August 22, 2024, at 12:50 p.m., LALD-A stated ULP-E had worked 160 hours as of June 20, 2023. The licensee's Dementia Education policy, effective August 1, 2021, indicated direct care employees must have completed at least eight hours of initial dementia education within 160 working hours of the employment start date in the following topics: - an explanation of Alzheimer's Disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. The policy also indicated until the initial education is complete, an employee will not provide direct care unless there is another employee on site who has completed the initial eight hours of education on topics related to dementia care and who can act as a resource and assist if issues arise. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01560	Continued From page 77	01560		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all 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 of the residents).	01560		

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	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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01560	Continued From page 78 The findings include: When interviewed on August 22, 2024, at 9:53 a.m., licensed assisted living director (LALD)-A stated he did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers, and indicated he was not aware of this requirement. The licensee's Notifications policy, effective August 1, 2021, indicated information regarding the training program for services to residents with dementia would be available to residents, families and others who request it, would be provided in written or electronic form, and would include categories of employees trained, the frequency of the training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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	01610		

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01610	Continued From page 79 is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a nursing assessment of the physical and cognitive needs of the resident for four of four residents (R1, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19, 2024, at 11:43 a.m., licensed assisted living director (LALD)-A stated the initial assessment was completed between the RN, an unlicensed personnel (ULP)-B, and himself. LALD-A stated the licensee used paper assessments, even though they had an electronic medical record, because the RN preferred that. LALD-A stated the initial assessment was completed during "intake."	01610		

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01610	Continued From page 80 R1 R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Resident Evaluation, identified as the initial assessment by LALD-A, was dated August 13, 2023, or two days after R1 moved in and began receiving housing and assisted living services. R4 R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Resident Evaluation, identified as the initial assessment by LALD-A, was dated April 20, 2022, or five days after R4 moved in and began receiving housing and assisted living services. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and received services including medication set-up, medication administration, housekeeping, and laundry. R5's Resident Evaluation, identified as the initial assessment by LALD-A, was dated August 6, 2023, or three days after R5 moved in and began receiving housing and assisted living services. R6 R6's start of services was April 12, 2024. R6 had diagnoses including anxiety, and received	01610		

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01610	Continued From page 81 services including medication set-up, medication administration, housekeeping, and laundry. R6's Resident Evaluation, identified as the initial assessment by LALD-A, was dated April 18, 2024, or six days after R6 began receiving housing and assisted living services. During an interview on August 21, 2024, at 9:19 a.m., LALD-A had no explanation as to why the initial assessments were not completed timely and stated he wished the RN would have been present to answer these questions. The licensee's Assessment and Reassessment policy, effective date August 1, 2021, indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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 82 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: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessment, not to exceed 14 calendar days from the date of start of services, and ongoing assessment not to exceed 90 days for one of three residents (R4). 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: R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received	01620		

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01620	Continued From page 83 services including medication set-up, medication administration, housekeeping, and laundry. R4's Resident Evaluation, identified as the initial assessment by licensed assisted living director (LALD)-A, was dated April 20, 2022, and another assessment available was dated October 5, 2022. On August 19, 2024, at 11:22 a.m., during entrance conference, LALD-A stated the RN documents the nursing assessments on paper but they were in the process of converting from paper to electronic health record (RTasks). LALD-A stated resident clinical charts were located in the lower-level office and the RN completed assessments initially, within 14 days, and ongoing every 90 days and with a change in condition. During interview on August 20, 2024, at 10:21 a.m., surveyor requested R4's nursing assessments completed after October 5, 2022, LALD-A stated he was unable to locate them in the office and would need to look elsewhere because the nurse may have them somewhere else. During interview on August 20, 2024, at 10:40 a.m., former clinical nurse supervisor (CNS)-D stated she "thought she completed [R4's] paper RN assessment a couple of months ago." CNS-D stated the assessments should be in the resident's clinical chart. The licensee's Assessment and Reassessment policy, effective date August 1, 2021, noted the RN will complete an initial assessment prior to the date which the prospective resident executes a contract, will provide a reassessment visit no	01620		

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01620	Continued From page 84 more than 14 days after initiation of services, and ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. The licensee's Clinical Record policy, effective date August 1, 2021, noted clinical records will be maintained in such a manner that allows for timely access, printing or transmission of the records. The policy also indicated the clinical record will include current and previous nursing assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	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,	01640		

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01640	Continued From page 85 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 the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of three residents (R1, R5). 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 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: During entrance conference on August 19, 2024, at 11:22 a.m., licensed assisted living director (LALD)-A stated the registered nurse created the service plan upon admission, then service plan would be updated within 14 days as necessary. LALD-A stated resident records are all on paper but they have recently began using their online charting program (RTasks) for medication administration. R1 R1's record lacked a service agreement between R1 and the licensee, since his admission on	01640		

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01640	Continued From page 86 August 11, 2023. R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Resident Evaluation, identified as the initial assessment by LALD-A, was dated August 13, 2023, or two days after R1 moved in and began receiving housing and assisted living services. R1's record included a "Service Plan: Part 1 and 2," dated August 13, 2023, which included handwritten notes that the RN (registered nurse) would complete quarterly assessments, "Every 3 months and as needed," with client review/reassessment on admission in person, within 14 days in person, every 90 days, and as needed, by the RN. Also included, monitoring/supervision of staff would be in person, by the RN. The remainder of the document was blank, and lacked a signature or other authentication by the resident or the RN, documenting agreement on the services to be provided. Attached to this document was "Service Plan: Part 3-Treatment Plan," and "Service Plan: Part 4-Medication Management Plan," which were also blank. An additional Service Plan was identified in R1's record, dated February 1, 2024, through January 31, 2025; however, was missing page 4 of 4 or the signature page, to document agreement on the services to be provided. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and received services including medication set-up, medication administration, housekeeping, and	01640		

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01640	Continued From page 87 laundry. R5's Resident Evaluation, identified as the initial assessment by LALD-A, was dated August 6, 2023, or three days after R5 moved in and began receiving housing and assisted living services. R5's record included a blank "Service Plan: Part 1 and 2," which was attached to "Service Plan: Part 4-Medication Management Plan," completed by former clinical nurse supervisor (CNS)-D on August 7, 2023. R5's record included a Service Plan signed on March 7, 2024. R5's record lacked a service agreement between R5 and licensee from August 3, 2023 through March 7, 2024. The licensee's Service Plan policy effective August 1, 2021, noted the following: "Procedure: 1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 3. The service plan must be revised, if needed, based on resident review or reassessment. 4. 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 was provided.	01640		

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01640	Continued From page 88 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

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01650	Continued From page 89 the required content for one of one resident (R4). 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: R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression. R4's Service Plan dated April 22, 2022, indicated services included medication administration, cueing on activities of daily living, assistance with laundry and housekeeping. R4's Individual Service Plan lacked the following required content: -the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of the staff or categories of staff who will provide the services. -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. On August 22, 2024, at 9:58 a.m., licensed assisted living director (LALD)-A stated that R4's service plan was the old version and since then they used a newer version.	01650		

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01650	Continued From page 90 The licensee's Service Plan policy effective date August 1, 2021, noted the service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party. b. The fees for services and the frequency of each service according to the resident's current review or assessment and resident preferences. c. The identification of the staff or categories of staff who will provide the services. d. The schedule and methods of monitoring reviews or assessments of the resident. e. The schedule and method of monitoring staff providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for one of two residents (R4).	01710		

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01710	Continued From page 91 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: R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Exhibit 2: Service Plan signed April 25, 2022, noted R4 received medication management services. R4's Resident Evaluation (nursing assessment) dated October 5, 2022, included a medication reassessment. R4's unsigned Physician's Order dated February 2023, signed by former clinical nurse supervisor (CNS)-D on December 8, 2022, noted the following: -olanzapine (for bipolar disorder) 5 milligram (mg) tablet-one tablet by mouth once daily as needed; and -olanzapine 20 mg-one tablet by mouth at bedtime. R4's unsigned Physician's Order dated February 2024, noted R4 took the following: acetaminophen as needed (PRN) for pain, hydroxyzine pamoate PRN for anxiety, ibuprofen	01710		

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	36569	A. BUILDING: _____ B. WING _____	08/22/2024

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01710	Continued From page 92 PRN for pain, naloxone PRN for overdose, olanzapine scheduled and PRN, oxycodone PRN for severe pain, senexon-s PRN for constipation, tizanidine PRN for muscle spasm, Gavilax PRN for constipation, vitamin D3 daily (supplement), and aspirin twice daily (prevent blood clots). R4's Medication Administration Record (MAR) dated August 2024, noted R4 took the following medications: aspirin twice daily, vitamin D3, olanzapine daily and PRN, ibuprofen, methocarbamol PRN (pain), oxycodone, senexon-s, and tizanidine. R4's record lacked medication reassessments for any change in condition/medication and annually. During email communication on August 20, 2024, at 12:34 p.m., the former CNS-D indicated she completed in person assessments and they would be found in resident records. Former CNS-D stated she was not notified if a resident returned to facility after a leave of absence and that this occurred often. The licensee's Assessment of Medications policy, effective date August 1, 2021, read medication reassessment will occur at the following times: -resident symptomology; -problems or concerns that may be medication-related; -with new prescription, OTC (over-the-counter) or herbal products; and -annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01750	Continued From page 93	01750		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency to a registered nurse (RN) for administering medications for two of two ULPs (ULP-E, ULP-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This resulted in an immediate order on August 21, 2024.	01750		

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01750	Continued From page 94 The findings include: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services for the residents, including medication set up by the clinical nurse supervisor (CNS)-D and ULPs administered those medications after being trained by CNS-D. ULP-E ULP-E was hired on May 1, 2023, to provide direct care services to residents of the assisted living facility. Review of R4 and R5's Med (medication) Admin (administration) Summary, dated August 2024, indicated ULP-E provided medication administration on August 5, 2024. ULP-E's record included an Educare (online training program) transcript that indicated ULP-E's medication training modules were assigned to her on July 26, 2024, however, indicated the status of completion was "Not Started." In addition, ULP-E's record lacked evidence the RN instructed the ULP in the proper methods to administer the medications, and ensured the ULP demonstrated the ability to competently follow the procedures. During a telephone interview on August 20, 2024, at 10:40 a.m., CNS-D stated she was no longer employed by the licensee and stated she was not familiar with ULP-E and had not provided training or competency evaluations for ULP-E. During an interview on August 21, 2024, at 3:05 p.m., LALD-A stated ULP-E did work alone and	01750		

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01750	Continued From page 95 administered medications. LALD-A stated he was certain ULP-E had received medication training because she worked at other facilities; however, stated he had no evidence of this. At 3:24 p.m., LALD-A stated he called ULP-E and she was going to send evidence of her medication administration training when she got home, and stated he did not have evidence of this prior to ULP-E administering medications to residents at this facility. ULP-C ULP-C was hired on July 15, 2024, to provide direct care services to residents of the assisted living facility. Review of R1's Med Admin Summary, dated August 2024, indicated ULP-C provided medication administration on August 5, 2024, August 8, 2024, August 12, 2024, August 13, 2024, August 14, 2024, and August 15, 2024. Review of R4's Med Admin Summary, dated August 2024, indicated ULP-C provided medication administration on August 8, 2024, and August 15, 2024. Review of R5's Med Admin Summary, dated August 2024, indicated ULP-C provided medication administration on August 5, 2024, August 12, 2024, August 13, 2024, August 14, 2024, and August 15, 2024. During an interview on August 19, 2024, at 3:12 p.m., the surveyor requested ULP-C's employee record from LALD-A. LALD-A stated he had been working on the paper record for ULP-C, and didn't have it available. During an interview on August 19, 2024, at 3:15	01750		

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01750	Continued From page 96 p.m., ULP-B stated ULP-C had been working alone with residents for a few weeks. During an interview on August 19, 2024, at 3:21 p.m., LALD-A stated ULP-C didn't work alone "all the time," but "some of the time, he did." Review of the employee schedule, dated August 11, 2024, through August 17, 2024, indicated ULP-C worked from 3:00 p.m. to 10:00 p.m. on August 12, 2024, August 13, 2024, August 14, 2024, and August 15, 2024. When interviewed on August 19, 2024, at 4:00 p.m., LALD-A stated he did not have any training records for ULP-C and stated the nurse had been working on training, but he didn't have any documentation of the training that had been completed. LALD-A stated the nurse would sign off completion at the end of the training. During email communication on August 20, 2024, at 12:34 p.m., the former CNS-D indicated she had not provided any training or competency testing for ULP-C. During a telephone interview on August 21, 2024, at 1:47 p.m., ULP-C stated he was not allowed to give medications yet, and had to wait until he had been properly trained before administering medications. When asked why his initials were noted on the Med Admin Summary, ULP-C stated, "I don't know. Call [LALD-A] or ULP-B." During an interview on August 21, 2024, at 2:32 p.m., LALD-A stated if ULP-C was alone, he never gave medications to residents and would only shadow another staff administering the medications. When asked why ULP-C's initials were documented on the Med Admin Summary	01750		

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01750	Continued From page 97 as administering the medications for the residents, as noted above, LALD-A stated the other staff would give the medications and ULP-C would document with his initials "for practice." The licensee's Delegation of Assisted Living Tasks policy, dated August 1, 2021, indicated the clinician (registered nurse or licensed health professional) was responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. The policy also indicated the clinician may delegate procedures according to the following: -clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident; -the clinician provided the [ULP] with written instructions specific to the resident; -the [ULP] demonstrated to the clinician competence in the procedure; and -the [ULP 's] competence is documented in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760		

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01760	Continued From page 98 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented after administration for two of two residents (R1, R4). In addition, the licensee failed to transcribe provider orders for one of one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services for the residents, including medication set up by the clinical nurse supervisor (CNS)-D and unlicensed personnel (ULPs) administered those medications for all residents after being trained by CNS-D. During observation on August 19, 2024, at 12:32	01760		

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01760	Continued From page 99 p.m., ULP-B poured R1's medications from the pill organizer into a paper cup. R1 swallowed the medications and left. ULP-B explained R1 sleeps in often and he would take his morning medications late because of it. MISSING DOCUMENTATION R1 R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Service Plan, dated February 1, 2024, through January 31, 2025, unsigned, indicated R1 received assistance with medication administration twice daily and as needed, and medication setup and monitoring twice daily. R1's Med (medication) Admin (administration) Summary-Month, dated August 2024, printed August 19, 2024, included: - acetaminophen (mild pain reliever) 500 milligrams (mg) one to two tablets by mouth (po) four times daily; - Daily-Vite Tab (supplement) one tablet po daily; - Flovent Hfa (prevent shortness of breath or wheezing) 44 micrograms (mcg) inhalation one puff twice daily; - oxybutynin (treat overactive bladder) 5 mg one tablet po twice daily; - vitamin D3 (supplement) 25 mcg one capsule po once daily; - trazodone (antidepressant) 50 mg one-half to one tablet po at bedtime; - diclofenac gel (topical pain reliever) 1% apply 2 grams to ankle two-three times daily as needed. Can self administer;	01760		

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01760	Continued From page 100 - hydroxyzine pamoate (treat anxiety) 50 mg one capsule po every 6 hours as needed; - ibuprofen (pain reliever) 600 mg one tablet po three times daily as needed; - methocarbamol (relaxes muscles) 500 mg one to two tablets po every 6 hours as needed; and - oxycodone (treat severe pain) 5 mg one to one and one-half tablets po every 4 hours as needed. R1's Med Admin Summary-Month, dated August 2024, lacked initials to indicate the medication had been administered for the following: - acetaminophen AM (morning) med administration missing initials on August 5, 6, 9, 10, 11, 13, 15, 16, 17; - Daily-Vite Tab AM med administration missing initials on August 5, 6, 9, 10, 11, 13, 15, 16, 17, 2024; - Flovent Hfa AM med administration missing initials on August 5, 6, 9, 10, 11, 13, 15, 16, 17, 2024; - oxybutynin AM med administration missing initials on August 5, 6, 9, 10, 11, 13, 15, 16, 17, 2024; - vitamin D3 AM med administration missing initials on August 5, 6, 9, 10, 11, 13, 15, 16, 17, 2024; - acetaminophen midday med administration missing initials on August 5, 6, 9, 10, 11, 13, 14, 15, 16, 17, 18, 2024; - acetaminophen afternoon (PM) med administration missing initials on August 6, 9, 13, 16, 2024; - Flovent Hfa PM med administration missing initials on August 6, 9, 13, 16, 2024; - oxybutynin PM med administration missing initials on August 6, 9, 13, 16, 2024; - trazodone PM med administration missing initials on August 6, 9, 13, 16, 2024; and - acetaminophen bedtime med administration	01760		

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01760	Continued From page 101 missing initials on August 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 2024. R4 R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Exhibit 2: Service Plan signed April 25, 2022, indicated R4 received medication management services. R4's unsigned Physician's Order, dated February 2024, indicated R4 took the following: acetaminophen as needed (PRN) for pain, hydroxyzine pamoate PRN for anxiety, ibuprofen PRN for pain, naloxone PRN for overdose, olanzapine scheduled and PRN, oxycodone PRN for severe pain, senexon-s PRN for constipation, tizanidine PRN for muscle spasm, Gavilax PRN for constipation, vitamin D3 daily (supplement), and aspirin twice daily (prevent blood clots). R4's Med Admin Summary-Month, dated August 2024, printed August 20, 2024, lacked initials to indicate the medication had been administered for the following: - aspirin 81 mg one tablet po twice daily AM med administration missing initials on August 6, 9, 10, 11, 13, 15, 16, 17, 18, 2024; - vitamin D3 1000 units (IU) five capsules po daily AM med administration missing initials on August 6, 9, 10, 11, 13, 15, 16, 17, 18, 2024; - aspirin PM med administration missing initials on August 5, 6, 7, 9, 12, 13, 14, 16, 18, 19, 2024; and - olanzapine 20 mg one tablet po daily PM med administration missing initials on August 5, 6, 7,	01760		

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01760	Continued From page 102 9, 12, 13, 14, 16, 18, 19, 2024. On August 21, 2024, at 2:41 p.m., LALD-A stated the missing initials were likely because the staff giving the medications forgot to chart that the medication was given. LALD-A stated the electronic medical record did not allow for them to go back and complete missed charting. When asked if the medications were actually given, LALD-A stated, "Probably," and added, the medications were "given but not charted." TRANSCRIPTION ERROR Review of R1's current Physician's Orders, signed June 13, 2024, noted the following discrepancies on the above Med Admin Summary-Month, dated August 2024, printed August 19, 2024: - Physician's Orders included an order for acetaminophen 325 mg one tablet every four hours as needed while R1's Med Admin Summary as noted above, included acetaminophen 500 mg one to two tablets four times daily; and - current Physician Orders lacked orders for hydroxyzine, methocarbamol, and oxycodone, as noted on the Med Admin Summary. On August 21, 2024, at 10:46 a.m., LALD-A could not explain R1's order discrepancies and stated he could not locate any other orders for R1. The licensee's Medication Documentation policy, effective August 1, 2021, noted each medication administered by [licensee] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Complete documentation of medication administration includes the following: a. resident's name	01760		

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01760	Continued From page 103 b. medication name c. medication dosage d. date and time of administration e. method/route of medication f. signature and title of staff administering the medication. The licensee's Prescriber's Orders policy, effective August 1, 2021, noted the registered nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed accurately at the time of set up for four of four residents (R1, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	01770		

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01770	Continued From page 104 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services for the residents, including medication set up by clinical nurse supervisor (CNS)-D and unlicensed personal (ULPs) administered those medications after being trained by CNS-D. LALD-A stated CNS-D completed medication setup on Mondays, and would be at the facility later that day. During the initial tour of the facility on August 19, 2024, at 12:45 p.m., the surveyor observed while ULP-B prepared to administer medications to R1. ULP-B washed his hands, and poured medications from a pill organizer into a paper medication cup. On August 20, 2024, at 7:50 a.m., ULP-B stated CNS-D did not show up to set up medications the day prior, but they had an extra week of meds for each resident, set up by CNS-D to use when she didn't get to the facility to set up medications for the next week, so they were using those. On August 20, 2024, at 10:39 a.m., CNS-D returned a phone call to the surveyor, and stated, as of last Monday, August 12, 2024, she was no longer working for the facility. On August 20, 2024, at 12:35 p.m., the surveyor observed while ULP-B poured three pills from R5's pill organizer into a paper medication cup	01770		

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01770	Continued From page 105 and administered them to R5. R1 R1's start of services was August 11, 2023. R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Med (medication) Admin (administration) Summary-Month, dated August 2024, included: - acetaminophen (mild pain reliever) 500 milligrams (mg) one to two tablets by mouth (po) four times daily; - Daily-Vite Tab (supplement) one tablet po daily; - Flovent Hfa (prevent shortness of breath or wheezing) 44 micrograms (mcg) inhalation one puff twice daily; - oxybutynin (treat overactive bladder) 5 mg one tablet po twice daily; and - vitamin D3 (supplement) 25 mcg one capsule po once daily. R1's record lacked documentation of weekly medication set up. R4 R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Med Admin Summary-Month, dated August 2024, included: - aspirin low tab 81 mg one tablet po twice daily; - vitamin D3 25 mcg five capsules po daily; and - olanzapine (antipsychotic) 20 mg one tablet po at bedtime.	01770		

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01770	Continued From page 106 R4's record lacked documentation of weekly medication set up. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and received services including medication set-up, medication administration, housekeeping, and laundry. R5's Med Admin Summary-Month, dated August 2024, included: - Biktarvy (suppresses HIV) 50/200/25 one tablet po daily; - gabapentin (treats nerve pain) 300 mg take three capsules po three times daily; and - quetiapine (treat bipolar disease) 100 mg one and one-half tablet po at bedtime. R5's record lacked documentation of weekly medication set up. R6 R6's start of services was April 12, 2024. R6 had diagnoses including anxiety, and received services including medication set-up, medication administration, housekeeping, and laundry. R6's Physician's Orders, dated January 12, 2023, included: - amlodipine besylate (treats high blood pressure) 10 mg one tablet po daily; - Daily-Vite Tab one tablet po daily; - vitamin D3 25 mcg take three capsules po daily; and - atorvastatin (lowers bad cholesterol levels) 40 mg one tablet po daily. R6's record lacked documentation of weekly	01770		

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01770	Continued From page 107 medication set up. On August 20, 2024, at 12:34 p.m., via email, CNS-D indicated she did medication setup every Monday, and would "usually put a note but no specific area to document." CNS-D also indicated she would use the electronic medical record initially to document medication setup, but on one occasion, she wanted to chart and realized her password was changed. LALD-A told her that he changed her password, and because that was done without CNS-D's consent, she stopped using the electronic medical record to chart. On August 21, 2024, at 9:48 a.m., LALD-A stated he wasn't aware of any documentation completed after medication setup by CNS-D. The licensee's Medication Documentation policy, effective August 1, 2021, indicated the licensee would document medication setup including date of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name/title of person completing medication setup, and documentation of medication set up would be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide	01790		

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01790	Continued From page 108 medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790		

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01790	Continued From page 109 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19, 2024, at 11:30 a.m., licensed assisted living	01790		

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01790	Continued From page 110 director (LALD)-A stated the licensee provided medication management services for the licensee's residents, including medication set up by the clinical nurse supervisor (CNS)-D and ULPs administered those medications after being trained by CNS-D. The licensee's Medication Management Plan for Residents Away from Home policy, effective August 1, 2021, indicated the registered nurse (RN) had developed written procedures/protocols for the ULPs, including special instructions regarding controlled substances, including: - the type of container(s) to be used for the medications appropriate to the facility's medication system; - how the container(s) should be labeled; - written information about the medications to be provided; - documentation requirements including date medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and any other information; and - how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or the designated representative. On August 20, 2024, at 1:19 p.m., ULP-B stated there were no written procedures to follow when a resident left the facility and medications were provided. ULP-B stated he just puts the medications in the envelope and he writes the time the resident should take them, noting "AM [morning] or PM [evening]." On August 21, 2024, at 12:14 p.m., LALD-A	01790		

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01790	Continued From page 111 stated the resident signed a form printed from the electronic medical record with information about the medications and was given the envelopes with AM or PM written on the outside; however, stated there were no written procedures when providing medications to the residents leaving the facility, as directed in the licensee's policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for four of four residents (R1, R4, R5, R6) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01820		

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01820	Continued From page 112 The findings include: During the entrance conference on August 19, 2024, at 11:22 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication administration to all residents and the registered nurse (RN) completed weekly medication set ups. LALD-A stated the licensee did not have any controlled medications. R1 R1 had diagnoses including fetal alcohol syndrome, post traumatic stress disorder, depression, and chemical dependency, and received services including medication set-up, medication administration, housekeeping, and laundry. R1's Service Plan, dated February 1, 2024, through January 31, 2025, unsigned, indicated R1 received assistance with medication administration twice daily and as needed, and medication setup and monitoring twice daily. R1's Med (medication) Admin (administration) Summary-Month, dated August 2024, printed August 19, 2024, included: - acetaminophen (mild pain reliever) 500 milligrams (mg) one to two tablets by mouth (po) four times daily; - Daily-Vite Tab (supplement) one tablet po daily; - Flovent Hfa (prevent shortness of breath or wheezing) 44 micrograms (mcg) inhalation one puff twice daily; - oxybutynin (treat overactive bladder) 5 mg one tablet po twice daily; - vitamin D3 (supplement) 25 mcg one capsule po once daily; - trazodone (antidepressant) 50 mg one-half to one tablet po at bedtime;	01820		

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01820	Continued From page 113 - diclofenac gel (topical pain reliever) 1% apply 2 grams to ankle two-three times daily as needed. Can self administer; - hydroxyzine pamoate (treat anxiety) 50 mg one capsule po every 6 hours as needed; - ibuprofen (pain reliever) 600 mg one tablet po three times daily as needed; - methocarbamol (relaxes muscles) 500 mg one to two tablets po every 6 hours as needed; and - oxycodone (treat severe pain) 5 mg one to one and one-half tablets po every 4 hours as needed. Review of R1's current Physician's Orders, signed June 13, 2024, noted the following discrepancies on the above Med Admin Summary-Month, dated August 2024, printed August 19, 2024: - Physician's Orders included an order for acetaminophen 325 mg one tablet every four hours as needed while R1's Med Admin Summary as noted above, included acetaminophen 500 mg one to two tablets four times daily; and - current Physician Orders lacked orders for hydroxyzine, methocarbamol, and oxycodone, as noted on the Med Admin Summary. On August 21, 2024, at 10:46 a.m., LALD-A could not explain R1's order discrepancies and stated he could not locate any other orders for R1. R4 R4's start of services was April 15, 2022. R4 had diagnoses including bipolar disorder (extreme mood swings) and depression, and received services including medication set-up, medication administration, housekeeping, and laundry. R4's Exhibit 2: Service Plan signed April 25, 2022, read R4 received medication management	01820		

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01820	Continued From page 114 services. R4's unsigned Physician's Order dated February 2024, read R4 took the following: acetaminophen as needed (PRN) for pain, hydroxyzine pamoate PRN for anxiety, ibuprofen PRN for pain, naloxone PRN for reversing overdose, olanzapine (for mood) scheduled and PRN, oxycodone (controlled medication) PRN for severe pain, senexon-s PRN for constipation, tizanidine PRN for muscle spasm, Gavilax PRN for constipation, vitamin D3 daily (supplement), and aspirin twice daily (prevent blood clots). R4's Medication Administration Record (MAR) dated August 2024, indicated R4 received the following medications: -aspirin 81 mg-one tablet by mouth twice daily; -vitamin D3 1000 units (IU)-five capsules by mouth daily; -olanzapine 20 mg-one tablet by mouth daily; -hydroxyzine pamoate (no dose listed)- 1 capsule by mouth every 6 hours PRN; -ibuprofen 800 mg-1 tablet by mouth three times daily PRN; -olanzapine (no dose listed)-1 tablet by mouth daily PRN; -oxycodone 5 mg- one tab by mouth every 6 hours PRN for severe pain; -senexon-s 8.6-50 mg- 2 tablets by mouth twice daily PRN for constipation; and -tizanidine 2 mg- 1-2 tablets by mouth every 6 hours PRN. R4's record lacked an order for all medications administered. R5 R5's start of services was August 3, 2023. R5 had diagnoses including anxiety and agitation, and	01820		

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01820	Continued From page 115 received services including medication set-up, medication administration, behavior management, housekeeping, and laundry. During observation on August 20, 2024, at 12:35 p.m., ULP-B administered gabapentin 300 mg-three capsules to R5. R5's MAR dated August 2024, indicated R4 received the following medications: -Biktarvy 50/200/25-1 tab by mouth daily (suppresses HIV); -gabapentin 300 mg-3 capsules by mouth three times a day (treat nerve pain); -hydrocortisone cream 2.5%-apply topically to rash twice daily; -quetiapine 100 mg-1 and one-half tablets by mouth at bedtime (antipsychotic); and -ibuprofen 600 mg-1 tablet by mouth four times daily PRN for pain. R5's provider orders dated June 4, 2024, listed two medications but the print was not legible. The order had a note indicating the following, "Quetiapine was decreased to 150 mg po (by mouth) q (every) HS (hour of sleep) at 3/15/24 visit with [name of provider]." R5's record lacked orders for all medications except quetiapine. R6 R6's restart of services was April 12, 2024. R6 had diagnoses including schizophrenia, memory deficits, arthritis, and generalized weakness. R6's nursing assessment dated April 18, 2024, noted R6 received assistance with bathing, dressing, grooming, transfers, and medication management.	01820		

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01820	Continued From page 116 R6's record lacked medication orders upon readmission, but included orders dated January 12, 2023. During interview on August 21, 2024, at 9:15 a.m., LALD-A stated he could not find R4's medication orders in the clinical chart, and stated he faxed the orders to the provider to be signed but took a long time to be returned. LALD-A confirmed there wasn't any oxycodone supply because R4 did not get a refill and it ran out but wasn't sure if R4's oxycodone order was discontinued or not but would find out. During interview on August 21, 2024, at 10:00 a.m., the surveyor inquired about R6's provider orders signed January 12, 2023, when his admission date was April 12, 2024. LALD-A stated R6 was readmitted after moving out for a period of time. During interview on August 21, 2024, at 11:00 a.m., LALD-A provided a fax receipt for R4 orders to be signed on May 28, 2024 but stated he never received signed orders from the clinic. The surveyor requested R5's order for Biktarvy and hydrocortisone cream, which were never received. During medication cabinet review on August 21, 2024, at 11:27 a.m., the surveyor observed R4's medication supply of olanzapine 20 milligrams (mg), polyethylene glycol (Gavilax), naloxone nasal spray (2 doses), and aspirin 81 mg. For R5, the surveyor observed Biktarvy and hydrocortisone cream. During interview on August 22, 2024, at 10:15 a.m., LALD-A explained R4 came from a	01820		

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01820	Continued From page 117 homeless shelter and didn't have medications with her, so they received medications from the pharmacy. The licensee's Medication Orders policy, effective date August 1, 2021, read licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. 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, 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	01880		

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	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01880	Continued From page 118 a large portion or all of the residents). The findings include: On August 19, 2024, at 11:22 a.m., during entrance conference, licensed assisted living director (LALD)-A stated resident medications were secured in a locked cabinet on the upper level. During facility tour on August 19, 2024, at 12:50 p.m., the surveyors asked to enter the attached garage. LALD-A obtained the key from unlicensed personnel (ULP)-B to open the garage entry door. Upon entry of attached closed two car garage, the surveyors observed multiple boxes and two full binders belonging to R2 (discharged August 7, 2023) sitting on top of a box in the center of the garage. Surveyors also observed R6's prescription bottle containing one 500 milligram (mg) tablet of Tylenol sitting on top of a different box. LALD-A was unsure why the prescription bottle was in the garage and removed it. On August 20, 2024, at 12:16 p.m., the surveyor went upstairs and saw keys with a small black canvas type tag sitting on a small red round table near the medication cabinet. The surveyor observed ULP-B sitting outside and no one else in the main area of the home. On August 20, 2024, at 12:35 p.m., during medication administration to R3, the surveyor observed a transparent plastic container sitting on top of the medication cabinet containing R6's Tylenol from the garage. The surveyor inquired why the bottle was in that container but ULP-B did not know why it was there. The surveyor also asked if the medication keys were always kept on his person, and ULP-B stated yes. The surveyor	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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01880	Continued From page 119 informed ULP-B what was observed prior and he stated the surveyor must have seen his personal keys which had a black car fob (showed surveyor his keys) which surveyor stated those were not the keys seen. The surveyors were set up in the living room of the lower level and adjacent to the living room was LALD-A's office which he kept the door open while he was out. On August 22, 2024, at 10:40 a.m., the surveyor inquired about a clear plastic container sitting on a shelf containing multiple medications in blister packs within the office. LALD-A stated the medications belonged to a former resident who discharged to the licensee's other facility and stated the pharmacy kept delivering to this facility and had not brought them over to the other facility yet. The surveyor observed the medications were dispensed by the pharmacy on August 5, 2024. LALD-A stated he left the office door opened because the surveyors were on site but explained he would leave it locked if he left the office. The surveyor explained to LALD-A that the office should remain locked if unoccupied. R3 was admitted to licensee on February 23, 2024, and discharged from licensee on April 29, 2024. R3's Resident Notes entry by LALD-A dated April 12, 2024, indicated R3 opened the locked office with a card and wire. A staff person ran downstairs and asked R3 why he opened the office, but no response was provided. LALD-A indicated it looked like R3 was trying to steal something but wasn't sure. Redirection was provided to R3. The licensee's Storage/Control of Medications	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING LLC	7949 BURNSWICK AVENUE NORTH BROOKLYN PARK, MN 55443

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01880	Continued From page 120 policy effective date August 21, 2021, indicated when the licensee was providing storage of medications outside of the resident's private living space, all prescription drugs were securely locked in substantially constructed compartments according to manufactures instructions and only authorized personnel would have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 121 by: Based on observation, interview, and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's record lacked documentation of medication disposition upon R3's discharge from the facility. R3's diagnoses included anxiety, substance dependence, fetal alcohol syndrome, obsessive compulsive disorder, attention deficit hyperactivity disorder (ADHD), and depression. R3 began receiving services on February 23, 2024, and was discharged on April 29, 2024, as indicated on the licensee's Discharged or Deceased Resident Roster: State Evaluations form, completed by licensed assisted living director (LALD)-A on August 19, 2024, when survey was initiated. R3's progress note in RTasks (electronic medical record used by the licensee) indicated on April 29, 2024, R3 had an argument with R1 and R3 hit R1 with a brick on his chest and caused injury. 911 was called and R1 was taken to the hospital. During an interview on August 21, 2024, at 12:36	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36569	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 122 p.m., LALD-A stated R3 was arrested and taken to jail on April 30, 2024, when R1 decided to press charges. LALD-A stated R3's discharge happened very quickly, and medications were sent with R3; however, there was no documentation in R3's record of the disposition of the medications. LALD-A stated he wasn't aware of the requirement to do so. The licensee's Disposition and Disposal of Medications policy, effective date August 1, 2021, indicated unused medications would be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications were no longer managed by the facility or the medication had been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *08/20/24*
Time: 10:50:38
Report: 1021241232

Food and Beverage Establishment Inspection Report

Location:
Senior Living Llc
7949 Burnswick Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039128
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634001819
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. STAFF REFERRED TO AND DOWNLOADED AN ELECTRONIC COPY OF THE ILLNESS LOG FROM THE MDH WEBSITE. MAKE SURE TO HAVE A COPY ON-SITE.

Comply By: 08/20/24

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT IS NOT SANITIZING EQUIPMENT AND UTENSILS. PER CONVERSATION WITH ALD, THEY ARE GETTING A DISH MACHINE. IN THE MEANTIME THEY ARE GOING TO SET UP A CONTAINER TO MANUALLY SANITIZE ALL DISHES AND UTENSILS WITH A SANITIZING SOLUTION.

Comply By: 08/20/24

2-100 Supervision

2-102.11ABCQ ***** Priority 2 *****

MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.

THE PERSON IN CHARGE WAS UNABLE TO DEMONSTRATE THEIR UNDERSTANDING OF THE SYMPTOMS COMMONLY ASSOCIATED WITH FOODBORNE ILLNESSES.

Comply By: 08/20/24

2-100 Supervision

2-102.11JKLM ***** Priority 2 *****

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

THE PERSON IN CHARGE MUST ENSURE THAT STAFF HAVE A FOOD THERMOMETER ON-SITE TO CHECK COOKING TEMPERATURES, A PROPER SYSTEM FOR CLEANING AND SANITIZING COOKING EQUIPMENT AND UTENSILS, AND THAT THE KITCHEN IS KEPT CLEAN.

Comply By: 08/20/24

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

ESTABLISHMENT DOES NOT HAVE CLEAR PROCEDURES ON HOW TO PROPERLY CLEAN UP A VOMITING/FECAL ACCIDENT. INFORMATION SENT WITH REPORT. MAKE SURE TO TRAIN STAFF ON THE PROPER PROCEDURES.

Comply By: 08/27/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON-SITE. PROVIDE A THIN-PROBE DIGITAL FOOD THERMOMTER AS SPECIFIED IN RULE ABOVE.

Comply By: 08/27/24

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. PROVIDE. ONE THERMOLABEL LEFT ON-SITE.

Comply By: 08/27/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

THERE IS NO HAND SOAP AVAILABLE IN THE DOWNSTAIRS BATHROOM. PROVIDE SOAP AND ENSURE THAT ALL HANDWASHING SINKS ARE STOCKED WITH SOAP THROUGHOUT ALL HOURS OF OPERATION.

Comply By: 08/21/24

6-300 Physical Facility Numbers and Capacities

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

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

THERE ARE NO PAPER TOWELS AVAILABLE IN THE DOWNSTAIRS BATHROOM. PROVIDE PAPER TOWELS AND ENSURE THAT ALL HANDWASHING SINKS ARE STOCKED WITH PAPER TOWELS THROUGHOUT ALL HOURS OF OPERATION.

Comply By: 08/21/24

2-100 Supervision

2-102.12AMN

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

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

Comply By: 09/20/24

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

ESTABLISHMENT WILL NEED A DISH MACHINE THAT MEETS THE ANSI STANDARD 184 FOR RESIDENTIAL DISHWASHERS. PROVIDE. DISH MACHINE FACT SHEET SENT WITH REPORT.

Comply By: 09/03/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE BUTCHER BLOCK COUNTERTOP AREA NEXT TO THE COFFEE MAKER HAS A BLACK STAIN. UNABLE TO VERIFY WHAT IT IS. THE CUTOUTS IN THE KITCHEN CABINETS HAVE ACCUMULATION OF DEBRIS. THE SIDE OF THE STOVE HAS ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/26/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

HANDWASHING SINKS IN THE KITCHEN AND IN THE BATHROOMS ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 08/23/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

SPIDERWEBS WERE FOUND ON THE WALL ABOVE THE STOVE. PLEASE CLEAN THE AREA AND MAINTAIN IT TO PREVENT ANY POTENTIAL CONTAMINATION OF FOOD.

Comply By: 08/20/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: HOT DOGS - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	7	5

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH ALD, ANKER CHOPRA, HOUSE MANAGER, TIM OYEDOKUN AND HEALTH REGULATION DIVISION NURSE EVALUATORS, LOANN DEGAGNE AND ANNA BOHNEN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, SOME FOOD MIGHT BE SAVED FOR ANOTHER DAY. DISCUSSED THAT ALL FOOD HAS TO BE DONE FOR SAME DAY SERVICE. NO LEFTOVERS CAN BE KEPT. THERE WERE NO LEFTOVERS IN THE KITCHEN REFRIGERATOR DURING VISIT.

CONTINUATION OF MN Rule 4626.0710B
STAFF WILL SEND INSPECTOR A PICTURE OF THE USED THERMOLABEL ONCE THEY GET A DISH MACHINE TO MAKE SURE IT IS REACHING THE CORRECT FINAL UTENSIL SURFACE

TEMPERATURE.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, BUTCHER BLOCK COUNTERTOPS, PAINTED DRYWALL AND VINYL FLOOR. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021241232 of 08/20/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____

ANKER CHOPRA
ALD

Signed:_____

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