DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 10, 2024

Licensee
Unity Trust Home Care
7333 Dupont Avenue North
Brooklyn Park, MN 55444

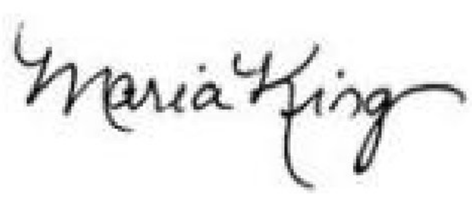
RE: License Number 414341
Health Facility Identification Number (HFID) 37041
Project Number(s) SL37041015

Dear Licensee:

On December 20, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed May 17, 2023. 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 Januray 5, 2024.

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,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 25, 2023

Licensee
Unity Trust Home Care
7333 Dupont Avenue North
Brooklyn Park, MN 55444

RE: Conditional License Number 409289
Health Facility Identification Number (HFID) 37041
Project Number(s) SL37041015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on August 8, 2023, to determine correction of orders found on the survey completed on May 17, 2023, and to assess compliance with state licensing statutes. Based on the follow-up survey results you were found to continue to 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 24, 2023.**

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on May 17, 2023, found not corrected at the time of the August 8, 2023, follow-up survey and/or subject to penalty assessment are as follows:

St - 0 - 0450 - 144g.41 Subdivision 1 - Minimum Requirements
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $500.00
St - 0 - 0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements - $500.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0550 - 144g.41 Subd. 7 - Resident Grievances; Reporting Maltreatment - $500.00
St - 0 - 0580 - 144g.42 Subd. 2 - Quality Management - $500.00
St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma
St - 0 - 0640 - 144g.42 Subd. 7 - Posting Information For Reporting Suspected - $500.00
St - 0 - 0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control - $500.00
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - $500.00
St - 0 - 0730 - 144g.43 Subd. 3 - Contents Of Resident Record - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) - Fire Protection And Physical Environment - $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $500.00
St - 0 - 0900 - 144g.50 Subdivision 1 - Contract Required
St - 0 - 0950 - 144g.50 Subd. 3 - Designation Of Representative - $500.00
St - 0 - 1060 - 144g.52 Subd. 9 - Emergency Relocation - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $500.00
St - 0 - 1330 - 144g.60 Subd. 4 (b) - Unlicensed Personnel - $500.00
St - 0 - 1440 - 144g.62 Subd. 4 - Supervision Of Staff Providing Delegated Nurs - $500.00
St - 0 - 1470 - 144g.63 Subd. 2 - Content Of Required Orientation - $500.00
St - 0 - 1500 - 144g.63 Subd. 5 - Required Annual Training
St - 0 - 1530 - 144g.64 - Training In Dementia Care Required - $500.00
St - 0 - 1610 - 144g.70 Subd. 2 (a-B) - Initial Reviews, Assessments, And Monitoring - $500.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $500.00
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $500.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $500.00
St - 0 - 1830 - 144g.71 Subd. 14 - Renewal Of Prescriptions
St - 0 - 1880 - 144g.71 Subd. 19 - Storage Of Medications - $500.00
St - 0 - 1910 - 144g.71 Subd. 22 - Disposition Of Medications
St - 0 - 1940 - 144g.72 Subd. 3 - Individualized Treatment Or Therapy Managemen - $500.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy
St - 0 - 1970 - 144g.72 Subd. 6 - Treatment And Therapy Orders - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

MDH may assess fines based on the level and scope of the order outlined below. The total amount of **potential** fine that may be assessed related to the correction order is **$3,000.00. MDH is not imposing the fine against your license at this time.**

St - 0 - 0340 - Correction Orders-144g.30 Subd. 5 - $3,000.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $19,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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.

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.

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

Please address your cover letter for reconsideration requests to:

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Unity Trust Home Care 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 an additional follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the next follow-up survey, MDH will determine if Unity Trust Home Care 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:** Unity Trust Home Care will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Unity Trust Home Care must provide MDH:

   i. A list of the names and birthdates of any individuals Unity Trust Home Care 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:** Unity Trust Home Care will contract with an RN to provide consultation concerning all resident(s) to whom Unity Trust Home Care provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Unity Trust Home Care. 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 Unity Trust Home Care and MDH must review the RN's credentials and approve the selection. Unity Trust Home Care is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Unity Trust Home Care in an effort to help Unity Trust Home Care 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. Unity Trust Home Care 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 Unity Trust Home Care and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Survey Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (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
   viii. Any other information requested by MDH or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Unity Trust Home Care to correct the violations cited during the August 8, 2023, follow-up survey as well as to determine the overall practice of Unity Trust Home Care 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.

f. **Follow-up survey:** At the time of the next 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.

g. **Corrective Action Plan:** Unity Trust Home Care 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 Unity Trust Home Care is in substantial compliance based on the results of the next follow-up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Unity Trust Home Care is in substantial compliance on the next follow-up survey, MDH will remove the conditions from Unity Trust Home Care's assisted living facility license, and Unity Trust Home Care will correct violations cited at the August 8, 2023, follow-up survey, to come into substantial compliance. If MDH determines Unity Trust Home Care is not in substantial compliance, MDH may take additional enforcement action against Unity Trust Home Care, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the

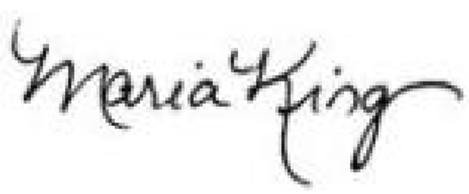
license holder received the order. The request for hearing should be addressed to:

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

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 Casey DeVries directly at: 651-201-5917.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37041015-1 On August 7, 2023, through August 8, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on May 17, 2023. At the time of the survey, there were three residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 340 SS=I	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders issued for a survey completed on May 17, 2023. This had the potential to affect all residents and staff of the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	0 340		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER

UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 340	Continued From page 2 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 revisit survey on August 7, 2023, through August 8, 2023, a review of the licensee's policies and procedures, resident records, and employee records lacked evidence to indicate the licensee had corrected all the orders issued for the survey concluded on May 17, 2023. On August 7, 2023, at 12:30 p.m., the surveyor requested licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated the licensee had not completed or implemented a plan of correction. LALD/RN-D also stated licensee had requested the service of a consultant to work with them to make the corrections but the consultant had not sent the report to the licensee. On August 8, 2023, at 10:50 a.m., during an interview with LALD/RN-D and licensed practical nurse (LPN)-A, the surveyor requested a signed contract between the licensee and the consultant hired to write a plan of correction. LALD/RN-D stated the licensee had not executed a contract with the consultant, but they had paid out some fee to the consultant. LALD/RN-D also stated the consultant came out to the licensee's facility and pointed out some required postings but the licensee had not heard back from them since. TIME PERIOD FOR CORRECTION: Two (2) days	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 450}	Continued From page 3	{0 450}		
{0 450} SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to one of two residents (R1). 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: R1 admitted to the licensee on September 29, 2022. R1's record lacked evidence the licensee	{0 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 450}	Continued From page 4 provided the BOR to R1 before initiating services. On May 16, 2023, at 10:20 a.m., licensed practical nurse (LPN)-A stated some resident information was locked in their offsite office, and the registered nurse (RN) responsible was out of the country with the keys. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information provided.	{0 450}		
{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	{0 470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 470}	Continued From page 5 safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. In addition licensee failed to ensure the required 24-hour staffing schedule was posted in a central location. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, at 10:10 a.m., during the entrance conference, licensed practical nurse (LPN)-A stated the licensee had a staffing plan that was evaluated two times per year. In addition, LPN-A stated the licensee's staffing plan included two staff for day, evening, and night	{0 470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 470}	Continued From page 6 shifts to care for the residents. On May 15, 2023, at 11:04 a.m., during the facility tour the surveyor did not observe a 24-hour staffing schedule posted in a central location. At 11:06 a.m., unlicensed personnel (ULP)-E stated their staffing schedule was posted in their online communication forum available only to staff. On May 16, 2023, at 9:53 a.m., LPN-A stated the licensee had a written a staffing plan, but it was locked in their offsite office location and the registered nurse (RN) responsible was out of the country with the keys. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{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	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 480}	Continued From page 7 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 17, 2023, for the specific Minnesota Food Code deficiencies. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. On August 8, 2023, at 1:45 p.m., the surveyor requested to know if the licensee had implemented a plan of correction for the orders issued by the environmental health (EH) surveyor. LALD/RN-D stated the licensee had not received any orders from EH. The surveyor then requested to see the email from the Minnesota Department of Health (MDH) which the licensee had received with their orders. When LALD/RN-D had opened the email, the surveyor pointed them to the EH report which needed the licensee's attention.	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 480}	Continued From page 8 No further information was provided	{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 interview and record review, the licensee failed to ensure staff had access to the registered nurse (RN), 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This resulted in an immediate correction order issued on May 16, 2023, at 4:45 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Licensed assisted living director (LALD)/RN-D started employment with licensee April 28, 2021, under the comprehensive license and the assisted living license on August 1, 2021. R2's nursing note dated May 8, 2023, indicated R2 was discharged from hospital and arrived at the licensee's facility accompanied by	{0 495}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 495}	Continued From page 9 paramedics. R2's Nursing Admission Assessment dated May 8, 2023, indicated R2 was readmitted to the facility after a hospitalization. There was no indication of who completed the assessment. R2's Medication Sign Out Form dated between May 8, 2023, and May 15, 2023, indicated unlicensed personnel (ULP) were responsible to administer medications to R2. R2's record lacked a service plan documenting agreement on the services to be provided. On May 15, 2023, at 10:20 a.m., ULP-E stated none of the licensee's nurses were available to participate in an entrance conference because licensed assisted living director (LALD/RN)-D was out of the country, and licensed practical nurse (LPN)-A was at her other work location. On May 15, 2023, at 10:30 a.m., ULP-E called LPN-A on the phone to complete the entrance conference. During the entrance conference, LPN-A stated LALD/RN-D was out of the country and would be returning this week. LPN-A also stated LALD/RN-D worked Mondays, Wednesdays, and Fridays. The licensee did not have a staffing plan for determining its staffing level. On May 16, 2023, at 11:38 a.m., LPN-A stated LALD/RN-D left the country on May 8, 2023, and was due to return May 19, 2023. LPN-A also stated ULP were instructed to call her (LPN-A) for assistance if needed. On May 16, 2023, at 11:50 a.m., ULP-B stated she tried to call LALD/RN-D yesterday for	{0 495}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 495}	Continued From page 10 personal reasons, but the call would not go through. ULP-B also stated in the absence of LALD/RN-D, they were instructed to reach out to LPN-A in case of any questions. On May 16, 2023, at 12:20 p.m., LPN-A stated R2 was hospitalized as a result of hallucinations and refusing to eat, and was discharged on May 8, 2023. LPN-A completed the readmission assessment because RN-D was not available to reassess R2 upon return. The Licensee's undated, Nursing Assessment and Reassessment of Residents policy indicated RN will reassess the resident any time the resident returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. On August 8, 2023, at 12:35 p.m., the surveyor requested to know when the RN returned to work and if the licensee had put a plan in place in case in the future the regular RN had to travel again. LALD/RN-D stated she came back May 18, 2023. LALD/RN-D also stated the plan was to have a part time RN incase the full time RN had to travel again and could not be reached over the phone. LALD/RN-D further stated it was only a plan in the works, the licensee had not written a policy for the same or implemented it.	{0 495}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 495}	Continued From page 11 No further information was provided.	{0 495}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-E, ULP-F). In addition, licensee failed to ensure a sharps container was provided to discard used sharps safely. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 510}	Continued From page 12 affect a large portion or all the residents). The findings include: On May 16, 2023, at 8:17 a.m., the surveyor observed ULP-B prepare breakfast without completion of hand hygiene. On May 16, 2023, at 9:30 a.m., the surveyor observed ULP-B and ULP-C assist R1 to dress and transfer into a wheelchair. ULP-B and ULP-C went directly into another resident's room with the same gloves used in R1's room. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare R1's medication without completion of hand hygiene. On May 17, 2023, at 8:19 a.m., the surveyor observed ULP-E and ULP-F don gloves before washing hands and walk into R1's room to complete blood glucose monitoring. ULP-E completed vital signs and administered medications, then ULP-F administered insulin and discarded the lancet and needle in the trash can in R1's room and proceed into the hallway with same gloves used for cares in R1's room. On May 17, 2023, at 9:40 a.m., ULP-E stated all staff are trained to maintain infection control procedures to ensure infection free work environment. ULP-E also stated the sharps container was in the nursing office, and should be in every resident room with blood glucose checks. On May 17, 2023, at 12:01 p.m., licensed practical nurse (LPN)-A stated all staff are trained on infection control methods and the importance to minimize infection. LPN-A also stated the sharps containers were available, if one was filled	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 510}	Continued From page 13 up, the ULP deliver it back to the office and pick up a new one. In addition LPN-A stated the registered nurse (RN) in charge of infection control was out on vacation. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in a Health Care Settings dated November 15, 2022, directed health care workers to wash their hands for at least 20 seconds with soap and water when hands are visibly dirty, before eating, after using restroom, and after caring for people. The U.S. Food and Drug Administration - Safely Using Sharps (Needles and Syringes) at Home, at Work and on Travel dated November 19, 2021, indicated used needles and other sharps are dangerous to people and pets if not disposed of safely because they can injure people and spread infections that cause serious health conditions. Also indicated, never place loose needles and other sharps (those that are not placed in a sharps disposal container) in the household or public trash cans or recycling bins, and never flush them down the toilet. This puts trash and sewage workers, janitors, housekeepers, household members, and children at risk of being harmed. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 550}	Continued From page 14	{0 550}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all five residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{0 550}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 550}	Continued From page 15 The licensee lacked a posting for the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. On May 15, 2023, at 11:10 a.m., during a facility tour, the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the grievance procedure. On May 15, 2023, at approximately 11:25 a.m., unlicensed personnel (ULP)-E verified the common areas lacked a grievance procedure posting with required content. On May 16, 2023, at 10:10 a.m., licensed practical nurse (LPN)-A stated the licensee provided each resident with a complaint form upon admission and licensee had not received any grievances. The licensee's undated Complaint and Investigation Process policy indicated residents will be informed of their right to complain to the facility about the services received and of the process to follow when making a complaint to the provider. Residents and their representatives will be informed that complaints may be made without fear of discrimination and/or retaliation. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued.	{0 550}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 550}	Continued From page 16 No further information was provided.	{0 550}		
{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 licensee failed to document its quality management activity. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: At the time of the survey, the licensee failed to	{0 580}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 580}	Continued From page 17 provide documentation of its quality management program. During the entrance conference on May 15, 2023, at 10:10 a.m., unlicensed personnel (ULP)-E stated the last meeting was held February 2023. He and three other employees attended the meeting. They discussed how to manage medication administration quality, housekeeping, resident activities of daily living, what had been working and not working, and what the licensee needed to improve. On May 16, 2023, at 11:15 a.m., licensed practical nurse (LPN)-A stated the licensee's quality management meeting notes were locked in their other office, but the registered nurse responsible was out of the country with the keys. The licensee's undated Quality Management Program policy indicated licensee "shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to our residents. All staff will be involved in the implementation of performance improvement activities. Outcome measurement of these activities will be monitored on a continuous basis and all results will be reported, at least annually, to the management team". On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued.	{0 580}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 580}	Continued From page 18 No further information was provided.	{0 580}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic	{0 630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 630}	Continued From page 19 bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's record lacked an IAPP with required content to include: - review or assessment of the R1's susceptibility to abuse by another individual, including other vulnerable adults; - R1's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. On May 17, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the IAPP was lacking in R1's record. LPN-A also stated the registered nurse who was responsible for the assessment, and would know if an IAPP was completed, was out on vacation. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated personnel are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse/neglect to that resident. In addition, all facility personnel rendering service to a resident are mandated to report maltreatment or injuries which are not reasonably explained to their supervisor or to the Minnesota Adult Abuse Reporting Center (MAARC). On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related	{0 630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 630}	Continued From page 20 to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 630}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC), and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	{0 640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 640}	Continued From page 21 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 May 15, 2023, at 11:20 a.m., during the facility tour, the surveyor observed a cordless phone and charger on the kitchen countertop near a resident common area. In addition, the surveyor observed the facility's main entry area and common areas lacked the required posted information as follows: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On May 16, 2023, at 10:27 a.m., licensed practical nurse (LPN)-A stated licensee was not aware of the requirement. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated personnel are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse/neglect to that resident. In addition, all facility personnel rendering service to a resident are mandated to report maltreatment or injuries which are not reasonably explained to their supervisor or to the Minnesota Adult Abuse Reporting Center (MAARC).	{0 640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 640}	Continued From page 22 On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction for orders issued related to the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 640}		
{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 establish and 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 documentation of a	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 660}	Continued From page 23 completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-B, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated June 24, 2020, indicated the licensee was low risk. The licensee failed to update and complete a TB risk assessment annually. ULP-B ULP-B started employment with licensee January 3, 2023, to provide assisted living services. ULP-B's employee record lacked the following required content: - Baseline TB screening to include: assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test; and - TB education. On May 16, 2023, at 12:40 p.m., ULP-B stated they completed a TB blood test and sent the results to registered nurse (RN)-D.	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 660}	Continued From page 24 ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services. ULP-F's employee record include a Baseline TB Screening Tool for Healthcare Workers (HCWs) incomplete form dated February 3, 2023. ULP-F's employee record lacked the following required content: - Baseline TB screening to include: assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test; and - TB education. On May 17, 2023, at 11:05 a.m., licensed practical nurse (LPN)-A stated ULP-B and ULP-F's employee records did not include the above required TB content. Additionally, LPN-A stated licensee could not access additional records in their other office, because licensed assisted living director/registered nurse (LALD/RN)-D locked it and went with the key on vacation. ULP-G ULP-G started employment with licensee June 13, 2023, to provide assisted living services. ULP-G's employee record include a Baseline TB Screening Tool for Healthcare Workers (HCWs) dated February 3, 2023. The HCWs indicated the ULP-G's history for current sysmptoms had been completed but the two step tuberculin skin test page was blank.	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 660}	Continued From page 25 On August 7, 2023, at 12:15 p.m., LALD/RN-D stated licensee had not completed ULP-G's TB skin test. LALD/RN-D also stated licensee was in the process to do a TB skin test for all empoyees. On August 7, 2023, at 12:30 p.m., the surveyor requested for the licensee's plan of correction for orders issued for the survey ended May 17, 2023, licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not done a plan of correction. Therefore, the correction order is being re-issued. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with residents must have documentation of baseline health screening prior to providing care to residents. This includes, at a minimum, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on agency risk assessment or a negative IGRA (blood test).	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 660}	Continued From page 26 On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 680}	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated binder with blank documents intended to be customized EP plan lacked the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information;	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 680}	Continued From page 28 - Emergency Officials Contact Information; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGININEERING); and - Integrated Health Systems; On May 16, 2023, at 1:15 p.m., licensed practical nurse (LPN)-A stated the licensee's EP plan was missing required information. LPN-A also stated the registered nurse who was responsible for the EP plan and would know if more information was available was out on vacation. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record 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;	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 730}	Continued From page 29 (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 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.	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 730}	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document for services provided as identified in the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. On May 16, 2023, at 11:30 a.m., the surveyor observed ULP-B assist home care nurse change R1's wound dressings. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose and later empty the colostomy bag. R1's Home Health Aide Care Plan dated September 29, 2022, indicated ULP's to empty R1's colostomy and Foley catheter bags at end of	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 730}	Continued From page 31 every shift and as needed. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: colostomy care, wound care, catheter care, ostomy care, and blood glucose monitoring three times daily. R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. R1's record lacked documentation for services provided to include the date and time of service, the signature and title of the person who completed the service. When services are not provided as ordered or prescribed, the provider must document the reason why it was not provided and any follow-up procedures that were provided to meet the resident's needs. On May 17, 2023, at 11:30 a.m., ULP-F stated all services provided are documented in the computer and on paper. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident record was locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 730}	Continued From page 32 licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 810}	Continued From page 33 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A facility tour was conducted on August 8, 2023, between approximately 11:30 a.m. and 12:30 p.m., with the licensed practical nurse (LPN)-A. It was observed that there were no posted evacuation plans or diagrams in the facility. LPN-A visually verified this deficient finding at the time of discovery. A record review and interview were conducted on August 8, 2023, at approximately 12:45 p.m. with the licensed assisted living director/ registered nurse (LALD/RN)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 810}	Continued From page 34 Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated for employees to exit the building, but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD/RN-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD/RN-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD/RN-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD/RN-D stated	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 810}	Continued From page 35 she had completed one training for her employees, but did not have documentation on employee training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, LALD/RN-D stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD/RN-D verified that there were no documented drills for the facility and verified this deficient condition. No further information was provided.	{0 810}		
{0 820} SS=F	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	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 820}	Continued From page 36 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 bedroom # 2 with the minimum window opening meeting the minimum state standard for egress. Licensee also failed to provide fire-rated ashtrays for resident use in smoking areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A facility tour was conducted on August 8, 2023, between approximately 11:30 a.m. and 12:30 p.m., with the licensed practical nurse (LPN)-A. It was observed that the egress window in unoccupied bedroom #2 was obstructed by a window air conditioning unit. Survey staff was unable to open the window in resident bedroom #2 on the main floor for measurement. The dimensions of the windowpanes of the double-hung window were 34 inches in width and 17 inches in height. Survey staff explained to	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 820}	Continued From page 37 LPN-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LPN-A verbally confirmed the findings and stated that the licensee had called a contractor to replace the window, but the contractor couldn't get to the facility until September 2023. LPN-A was not able to provide any documentation of the phone call or schedule of work. Egress windows in existing sleeping rooms must have a minimum openable width of 20" and minimum openable height of 20" with no less than 648 square inches total of openable area (4.5 square feet) for the window. It was observed that the wooden deck area and the main entrance, located under a breezeway, were being used as smoking areas. The main entrance is immediately adjacent to the only window for resident bedroom #2 and was not provided with a fire-rated ashtray. The wooden deck was off the kitchen area and was not provided with a fire-rated ashtray. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if residents' cigarettes were not completely extinguished before discarding them. LPN-A verbally confirmed the findings. No further information was provided.	{0 820}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 900}	Continued From page 38 (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 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 develop and execute a written contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 900}	Continued From page 39 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's record lacked a written Assisted Living contract to include the required content executed with the resident prior to providing assisted living services. On May 17, 2023, at 10:40 a.m., licensed practical nurse (LPN)-A stated R1's contract was not in R1 resident record folder. Additionally, LPN-A stated an extra copy would be in licensee's other office but could not access it as licensed assisted living director/registered nurse (LALD/RN)-D locked the office and went the key on vacation. The licensee's undated Assisted Living Contracts policy indicated licensee will establish a contract with each resident at the time of admission to the program. The contract will be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents will receive an unsigned copy of the contract and an unsigned	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 900}	Continued From page 40 copy will be provided for the Office of the Ombudsman for Long-Term. Care. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 900}		
{0 950} SS=F	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 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	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 950}	Continued From page 41 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 offer the residents the opportunity to identify a designated representative in writing in the contract. In addition, licensee failed to provide the required verbatim notice on a document separate from the contract for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's unsigned Resident Contract for Assisted Living dated December 8, 2022, had a section on	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{0 950}	Continued From page 42 the first page titled Designated Representative which was blank, the contract also lacked the required verbatim notice. On May 17, 2023, at 11:07 a.m., licensed practical nurse (LPN)-A stated they thought the contract was completed with all required content. LPN-A also stated licensee was not aware of resident designation of representative, hence none of the residents would have a designated representative. The licensee's undated Assisted Living Contracts policy indicated licensee will establish a contract with each resident at the time of admission to the program. The contract will be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents will receive an unsigned copy of the contract and an unsigned copy will be provided for the Office of the Ombudsman for Long-Term Care. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{0 950}		
{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	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01060}	Continued From page 43 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not 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	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01060}	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, for two of two residents (R2, R5) and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of two residents (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) 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: R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's nursing progress note dated May 8, 2023, at 1:00 p.m., indicated R2 was received back to licensee after a hospital stay. On May 8, 2023, at 1:05 p.m., the licensed practical nurse (LPN)-A stated they could not remember when R2 was sent to hospital, neither	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01060}	Continued From page 45 could they find a written nursing note. R2's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. R5 R5 was admitted to licensee on February 1, 2023, for assisted living services. R5's progress note dated May 2, 2023, indicated R5 had an uncontrolled pulse which necessitated the licensee to send R5 to hospital. On May 15, 2023, at the time of the survey, R5 still remained in the hospital 13 days later. R5's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The licensee also failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required. On May 16, 2023, at 1:15 p.m., LPN-A stated the licensee had not provided to the resident, resident's representative or to the ombudsman's office the required notices for emergency relocation as the licensee was not aware of the requirement. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. Licensed assisted living director/registered nurse (LALD/RN)-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued.	{01060}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01060}	Continued From page 46 No further information was provided.	{01060}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to staff providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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).	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01290}	Continued From page 47 The findings include: ULP-B ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E started work at the licensee's facility on January 31, 2022. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare and check blood glucose and administer medications to R1. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. On May 17, 2023, at 9:00 a.m., the surveyor observed ULP-F administer medications to R1. On May 16, 12:30 p.m., the NetStudy 2.0 website indicated ULP-B, ULP-E, and ULP-F were cleared and affiliated to licensee's active comprehensive home care license under the same ownership as the licensee. On May 16, 2023, at 2:30 p.m., licensed practical nurse (LPN)-A stated ULP-B, ULP-E, and ULP-F's background studies were in another of licensee's office but could not access it, as it was locked, and licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. ULP-G	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01290}	Continued From page 48 ULP-G started work at the licensee's facility on June 13, 2023. On August 7, 2023, at 11:25 a.m., the surveyor observed ULP-G and LALD/RN-D assist to transfer R1 into his wheelchair. ULP-G's record indicated a background study was done on June 20, 2023. On August 8, 2:10 p.m., the NetStudy 2.0 website indicated ULP-G was affiliated to the licensee's current comprehensive license. ULP-H ULP-H started work at the licensee's facility on April 28, 2023. On August 7, 2023, at 1:23 p.m., the surveyor requested to know if ULP-H was working, LPN-A stated ULP-H wash scheduled to work but did not show up. LPN-A also stated when she called ULP-H, he said he had quit the job and will no longer work with licensee. On August 8, 2023, the surveyor requested LALD/RN-D to pull up ULP-H's information on licensee's NetStudy 2.0 website. LALD/RN-D stated licensee forgot to complete a background study for ULP-H, therefore, no information was available for ULP-H on licensee's NetStudy 2.0 website. The licensee's undated Background Studies policy indicated licensee requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01290}	Continued From page 49 are confidential and are retained in confidential employee files. Employees will not be able to start working with residents until the background check clearance has been received by the facility. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01290}		
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01330}	Continued From page 50 review, the licensee failed to ensure employee training and competency was completed, to include all required content, for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. On May 16, 2023, at 9:45 a.m., the Nursing Assistant Registry website indicated ULP-B had a current certification with an expiration date October 10, 2023. ULP-B's employee record lacked competencies to include the following: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them;	{01330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01330}	Continued From page 51 - reading and recording temperature, pulse, and respirations of the client; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-E ULP-E started work at the licensee's facility on January 31, 2022. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare and check blood glucose and administer medications to R1. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. ULP-E, and ULP-F's employee records lacked training and competency evaluation to include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - documentation requirements for all services	{01330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01330}	Continued From page 52 provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Qualification, Training and Competency policy indicated licensee shall provide training to all staff providing and supervising assisted living services at the time of hire, and as needed to meet state guidelines and quality standards. Also indicated all staff members must be competent in the provision of services consistent with current practice standards appropriate to the resident's need and support the assisted living bill or rights.	{01330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01330}	Continued From page 53 On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided	{01330}		
{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 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	{01440}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01440}	Continued From page 54 review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the task was delegated for two of two unlicensed personnel ((ULP)-B, ULP-F). 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-F prepare and check blood glucose and administer medications to R1. ULP-B and ULP-F's employee record lacked documentation of supervision within 30 calendar days after the date medication administration and treatment tasks were delegated. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another	{01440}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01440}	Continued From page 55 office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Supervision of Unlicensed Personnel policy indicated licensee shall provide personal care and supportive services by unlicensed personnel under the direction and supervision of a registered nurse or other licensed health professional. Also indicated ULP shall be supervised periodically where the services are being provided to verify the work is performed competently and to identify problems and solutions related to staff ability to provide the care. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{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	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01470}	Continued From page 56 626.557 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 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	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01470}	Continued From page 57 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 orientation to assisted living facility licensing requirements before providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-F), 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. ULP-B employee record included undated and unsigned Staff Orientation Outline and Sign-Off which indicated licensee was using outdated Orientation to Home Care Requirements instead of assisted living (AL). ULP-F ULP-F started work at the licensee's facility on	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01470}	Continued From page 58 February 3, 2023. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-F prepare and check blood glucose and administer medications to R1. ULP-B and ULP-F's employee records lacked orientation in the following AL topics: - 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; - Assisted Living bill of rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; and - Orientation to each specific resident and services provided [144G.63 Subd. 3]. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Facility Employee Orientation policy indicated all employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the Facility, shall complete an orientation on topics required by	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01470}	Continued From page 59 Minnesota statutes and rules for assisted living. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01470}		
{01500} SS=D	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	{01500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01500}	Continued From page 60 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. 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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01500}	Continued From page 61 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E started work at the licensee's facility on January 31, 2022. ULP-E's employee record lacked annual training for at least eight hours of annual training for each 12 months of employment in the following topics: - training on reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights; - review of infection control techniques; - review of the facility's policies and procedures. - review of person-centered planning/service delivery; and - added 2 hours of dementia training. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01530} SS=F	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 all staff received eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-B, ULP-F).	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01530}	Continued From page 63 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 ULP-B started work at the licensee's facility on January 3, 2023. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. ULP-B and ULP-F's employee records lacked at least eight hours of initial dementia training on 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. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01530}	Continued From page 64 employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01530}		
{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 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	{01610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01610}	Continued From page 65 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment within the required timeframe for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism.	{01610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01610}	Continued From page 66 R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R1 and R2's records lacked Initial RN assessments by a registered nurse of the physical and cognitive needs of the prospective resident to 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 is earlier. On May 17, 2023, at 1:45 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the licensee will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Also indicated Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May	{01610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01610}	Continued From page 67 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information provided.	{01610}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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 a comprehensive nursing	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01620}	Continued From page 68 assessment within the required timeframe for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01620}	Continued From page 69 assistance, dressing assistance, and positioning/transfer. R2's nursing note dated May 8, 2023, indicated R2 was discharged from the hospital and arrived at the licensee's facility accompanied by paramedics. R2's Nursing Admission Assessment dated May 8, 2023, indicated R2 was readmitted to the facility after a hospitalization. There was no indication of who completed the assessment, and it lacked to cover the uniform assessment tool content as required. R1 and R2's records lacked reassessment and monitoring conducted no more than 14 calendar days after initiation of services, and ongoing resident reassessment and monitoring 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. On May 17, 2023, at 1:45 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the licensee will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Also indicated Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01620}	Continued From page 70 changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information provided.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01640}	Continued From page 71 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided.	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01640}	Continued From page 72 On May 17, 2023, at 11:06 a.m., licensed practical nurse (LPN)-A verified R1's record lacked a signed service plan. LPN-A stated R1 could not sign any document because he had encephalitis which had affected his limbs. LPN-A also stated licensee had a conversation with R1's case worker regarding signing documents, and reached agreement that R1's documents could remain unsigned. The surveyor requested documentation of the agreement with the case worker, but LPN-A stated licensed assisted living director (LALD/RN)-D who would know if this agreement was documented had traveled for vacation. The licensee's undated Service Plan policy indicated the service plan would be signed and dated when updated and/or revised by the resident and/or resident representative documenting agreement on the services to be provided. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01640}		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01730}	Continued From page 73 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01730}	Continued From page 74 review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services to include medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated R1 received medications on various dates. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 was taking the following medications, not all included: zinc gluconate 50	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01730}	Continued From page 75 milligram (mg) tablet take one-half tablet by mouth once daily for open wound of buttocks, cholecalciferol (vitamin D3) 5,000 units tablet take one tablet (5,000 units by mouth once a day, polyethylene glycol 17 gram (g) per dose powder mix one scoop (17 g) in liquid then take by mouth twice dally, tamusulosin 0.4 mg capsule take one capsule by mouth every day after meal, acetaminophen 325 mg tablet take two tablets (650 mg) by mouth every six hours if needed for pain maximum dose 4000 mg in 24 hours, baclofen 20 mg tablet (Lioresal) take two tablets (40 mg) by mouth three times daily, Basaglar KwikPen (u-100) insulin 100 units/ml (3 ml) pen(glargine) Inject 8 units subcutaneous at bedtime, insulin Aspart (u-100) 100unlts/ml (3 ml) pen (Novolog Flex Pen) inject 0-6 units subcutaneous three times a day with meals per sliding scale. R2 R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services to include medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. R2's Medication Sign out Form dated between May 8, 2023, through May 15, 2023, indicated R2 received medications on various dates. R2's unsigned Physician Order form indicated R2 was taking the following medications: ammonium lac 12% lotion 225 gm topical apply to both feet twice a day, acetaminophen 325 mg tablet take two tablets by mouth every four hours as needed	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01730}	Continued From page 76 pain or fever, clonidine 0.1 mg tablet take one tablet by mouth every night at bedtime, bupropion hcl 300 mg xl tablet take one tablet by mouth daily, vitamin D3 1,000 unit capsule take two capsules (2000 units) by mouth daily, and duloxetine 30 mg capsule take one capsule by mouth twice a day. R1 and R2's records lacked an individualized medication management record with required content to include: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01730}	Continued From page 77 out of the country with the keys. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01730}		
{01750} SS=F	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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel demonstrated the ability to competently follow the procedures for two of two employees (unlicensed personnel (ULP)-B, ULP-F). This practice in a level two violation (a violation	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01750}	Continued From page 78 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 ULP-B started employment with licensee January 3, 2023, to provide assisted living services including medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. On May 16, 2023, at 9:00 a.m., ULP-B stated RN-D trained her to pass medications, and she followed another ULP for two weeks before starting to administer medication on her own. ULP-B also stated the pharmacy sets up all medications in blister packs. R2's Medication Sign out Form dated between May 8, 2023, through May 15, 2023, indicated ULP-B administered medications on various dates. ULP-B's employee record lacked training or competency testing on medication administration. ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services including medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed ULP-F administer medications to R1.	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01750}	Continued From page 79 On May 17, 2023, at 9:35 a.m., ULP-F stated RN-D trained him, and he followed another ULP. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated ULP-F administered medications on various dates. ULP-F's employee record lacked training or competency testing on medication administration. On May 17, 2023, at 12:30 p.m., licensed practical nurse (LPN)-A stated all licensee's training and competency testing was completed during orientation of new employees. LPN-A stated if there were any additional records, then licensed assisted living director/registered nurse (LALD/RN)-D would be in a better position to provide them, but was out on vacation. The licensee's undated Medication Management Services policy indicated "the RN will develop and implement medication training curriculum and competency evaluations to assure that licensed and unlicensed staff are trained and competent to perform all delegated medication management tasks". On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01760}	Continued From page 80	{01760}		
{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 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 the resident's medication administration was documented in the resident's record and the documentation included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01760}	Continued From page 81 R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services to include medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated R1 received medications on various dates, but the form only gave the date, the time, number of medications administered, and the initials of person administering medications. R2 R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services to include medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. R2's Medication Sign out Form dated between May 8, 2023, through May 15, 2023, indicated R2 received medications on various dates, but the form only gave the date, the time, number of medications administered, and the initials of person administering medications. On May 16, 2023, at 8:20 a.m., when the	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01760}	Continued From page 82 surveyor inquired how the ULP knew what medications they had administered, ULP-B stated they were to trained to document like that, and the medication names and times were on the blister packs. R1 and R2's medication administration record (MAR) lacked the following content: - the signature and title of the person who administered the medication; - the medication name; - the medication dosage; and - method and route of administration. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated licensee preferred their documentation as it was easy and avoided medication errors. Further, LPN-A stated all medication names and times were printed on the blister packs and all ULP's were aware. The licensee's undated Documentation of Medication Administration policy indicated staff will refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. The profile or the MAR will also tell staff what side effects or problems to watch for and report. Also indicated to document the medication reminder or administration, initial the appropriate box (or enter electronically) on the MAR form to verify the medication has been administered at the appropriate time and date. All staff administering medications to a resident must include the staff person's name/initials and title in the signature box on the MAR or applicable authentication. On August 7, 2023, at 12:30 p.m., the surveyor	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01760}	Continued From page 83 requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01760}		
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and	{01830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01830}	Continued From page 84 hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's record included unsigned Physician Order form dated December 1, 2022, indicated R2 was taking the following medications: ammonium lac 12% lotion 225 gm topical apply to both feet twice a day, acetaminophen 325 mg tablet take two tablets by mouth every four hours as needed pain or fever, clonidine 0.1 mg tablet take one tablet by mouth every night at bedtime, bupropion hcl 300 mg xl tablet take one tablet by mouth daily, vitamin D3 1,000 unit capsule take two capsules (2000 units) by mouth daily, and duloxetine 30 mg capsule take one capsule by mouth twice a day. R2's record lacked prescriptions renewed at least every 12 months or more frequently as indicated by the assessment. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Medication Prescriptions & Refills indicated RN is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, are addressed in the resident's care plan, service plan and Medication Administration Record, and	{01830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01830}	Continued From page 85 are communicated to all appropriate staff. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01830}		
{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 and interview, the licensee failed to 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 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:	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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 86 On May 17, 2023, at 11:35 a.m., the engineering surveyor found multiple medications stored in a closet in an unoccupied bedroom within the facility. The door to the bedroom was unlocked and the medications were in small plastic bins on the shelf of a closet. Pictures of medications were obtained. On May 17, 2023, at 12:30 p.m., licensed practical nurse (LPN)-A stated licensee was aware of the medications being stored inappropriately in the vacant room. LPN-A stated the medications were not used and that they were intended for disposition, but licensee had not done it. The licensee's undated Medication Disposition or Disposal policy indicated licensee will develop policies to be followed in disposing of medications that are no longer used or after the resident has been discharged or has died. Facility staff will have guidelines to follow and will contact RN if there are questions or concerns. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information provided.	{01880}		
{01910} SS=D	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	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01910}	Continued From page 87 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 by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content one of two discharged residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 discharged from the licensee on December 10, 2022.	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01910}	Continued From page 88 R3's Hourly Nursing Services Progress Note dated December 10, 2022, indicated R3 died in her room, and hospice nurse coordinated transfer to the morgue. R3's record lacked a medication disposition record with required record to include: - 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. On May 16, 2023, at 10:10 a.m., licensed practical nurse (LPN)-A stated R3 received medication administration services, but R3's record was locked in another office location and LPN-A could not access it as licensed assisted living director (LALD/RN)-D had traveled with the keys. LPN-A also stated all medications are disposed and signed off by two people. The licensee's undated Medication Disposal policy indicated licensee will develop policies to be followed in disposing of medications that are no longer used or after the resident has been discharged or has died. Facility staff will have guidelines to follow and will contact RN if there are questions or concerns. The policy also indicated all the missing content will be included in resident record. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01910}	Continued From page 89 completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information provided.	{01910}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01940}	Continued From page 90 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan (ITMP) to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: wound care and blood glucose monitoring three times daily.	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01940}	Continued From page 91 R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose. R1's ITMP lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 17, 2023, at 11:40 a.m., licensed practical nurse (LPN)-A stated licensee's nurse was responsible for daily wound care, and thought the document they used was sufficient. LPN-A also stated was not sure if licensee had any further documentation other than what was provided. The licensee's undated Treatment and Therapy	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01940}	Continued From page 92 Management Plan policy indicated the individualized plan for each resident receiving treatment or therapy services will be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. The policy also indicated the missing content above will be included. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01940}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01950}	Continued From page 93 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: blood glucose monitoring three times daily. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received.	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01950}	Continued From page 94 ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services including delegated treatments. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose. On May 17, 2023, at 9:00 a.m., ULP-F stated he only remembered following another ULP for about two weeks before starting to provide cares. ULP-F's records lacked information RN had instructed in the proper methods with respect to each resident and ULP-F had demonstrated the ability to competently follow the procedures. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Treatment and Therapy Management Plan policy indicated when administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse or authorized licensed health professional has: - instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedure; - specified in writing detailed instructions for each resident and documented the instructions in the resident's record; and - communicated with the unlicensed personnel about the individual needs of the resident.	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01950}	Continued From page 95 On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01950}		
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01970}	Continued From page 96 The findings include: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: blood glucose monitoring three times daily. R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F prepare and check R1's blood glucose and later empty the colostomy bag. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received. On May 17, 2023, at 11:20 a.m., licensed practical nurse (LPN)-A stated licensee was using the after-visit summary as R1's current orders. LPN-A also stated if there were other orders licensed assisted living director (LALD/RN)-D would best answer, but LALD/RN-D was out of the country on vacation.	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{01970}	Continued From page 97 The licensee's undated Treatment and Therapy Management Plan policy indicated orders must be obtained for medications, treatments or therapies that would require orders from an authorized provider before the services are provided. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{01970}		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for two of two residents (R1 and R2) who utilized bed rails. This resulted in an immediate correction order issued on May 17, 2023, at 1:30 p.m. 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,	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{02310}	Continued From page 98 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. On May 16, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B, and ULP-C transfer R1 from the bed into his power wheelchair. R1's hospital bed had bilateral rectangular bed rails measuring approximately 32 inches long by 15 inches tall. The middle space of the bed rail had 10 vertical bars which were about four inches apart. R1's record lacked the following bed rail information: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion; - the resident's preferences; and - any necessary information related to interventions to mitigate safety risk or negotiated	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{02310}	Continued From page 99 risk agreements. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's Side-Rail Use Assessment Form dated December 8, 2022, indicated R2 used a side rail to promote independence. On May 17, 2023, at 12:03 p.m. the surveyor and unlicensed personnel (ULP)-E observed R2's hospital bed had bilateral rectangular bed rails measuring approximately 30 inches long by 12 inches tall. The middle space of the bed rail had three vertical bars and two horizontal bars which divided the bed rail into six open spaces and about four inches apart. R2's record lacked the following bed rail information: - measurements; - risk vs. benefits discussion; - the resident's preferences; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On May 17, 2023, at 12:26 p.m., licensed practical nurse (LPN)-A stated she was unaware	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{02310}	Continued From page 100 of the required documentation because the registered nurse (RN) managed it. LPN-A further stated the information was in a different location, and she did not have access to it. On August 7, 2023, at 12:30 p.m., the suveyor requested to know why the licensee had not responded to the immediate correction order issued on May 17, 2023, at 1:30 p.m. LALD/RN-D stated licensee had responded to the Minnesota Department of Health (MDH) through an email. LALD/RN-D then provided the surveyor with an email correspondence dated May 25, 2023, to one of the MDH's supervisor. When the surveyor opened the email it had no content to it and the attachment there in was uncompleted Side-Rail Use Assessment form. R1's Side - Rail Use Assessment Form dated May 19, 2023, signed by R1 and the licensee representative indicated RN had completed an assessment and provided risks and benefits for bedrail use. The form measurement further indicated the bedrail measurements were approximately 30 inches (in) long by 12 in tall and the middle space of the bedrail had 10 vertical bars which were about four inches apart. The form lacked to identify the sections/zones of the bedrail requiring measurements. Guidance for Industry and Food and Drug Administration (FDA) Staff - Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated the following zones are potential for entrapment and recommend that the zones be measured: Zone 1: Within the Rail - less than 120 mm (4 ¾ inches); Zone 2: Under the Rail, Between the Rail	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		R 08/08/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
{02310}	Continued From page 101 Supports or Next to a Single Rail Support - less than 120 mm (4 ¾ inches); Zone 3: Between the Rail and the Mattress - less than 120 mm (4 ¾ inches); and Zone 4: Under the Rail, at the Ends of the Rail - less than 60 mm (2 3/8 inches). The licensee's undated, Use of Side Rails policy indicated side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. On August 7, 2023, at 12:30 p.m., the surveyor requested the licensee's plan of correction related to orders issued for the survey concluded on May 17, 2023. LALD/RN-D stated licensee had not completed or implemented a plan of correction. Therefore, the correction order is being re-issued. No further information was provided.	{02310}		

Electronically Delivered

June 15, 2023

Licensee
Unity Trust Home Care
7333 Dupont Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL37041015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796
PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER

UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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: SL37041015-0 On May 15, 2023, through May 17, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents receiving services under the Assisted Living license. An immediate correction order was identified on May 16, 2023, issued for SL37041015-0, tag identification 0495. An immediate correction order was identified on May 17, 2023, issued for SL37041015-0, tag identification 2310. The licensee did not acknowledge the issuance of the immediate correction orders during the survey and the immediacy of 0495 and 2310 was not removed at the time of exit on May 17, 2023, at 2:15 p.m.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110 SS=C	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 for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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: On May 15, 2023, at 10:00 a.m., licensed practical nurse (LPN)-A stated registered nurse (RN)-D was the LALD for the licensee. LALD/RN-D obtained an assisted living director license on March 25, 2022. On May 15, 2023, at 11:35 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/RN-D held a current assisted living director license but was not listed as Director of Record for the licensee.	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110	Continued From page 2 On May 15, 2023, at approximately 11:40 a.m., LPN-A stated licensee was not aware of the requirement and LALD/RN-D who could be in position to answer was out on vacation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 320 SS=F	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide requested necessary resident and staff records to determine	0 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 320	Continued From page 3 compliance to licensure laws and rules. 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: On May 15, 2023, at 8:17 a.m., the surveyor emailed the licensee the survey introduction letter informing the licensee of the survey, the need to have the RN available, and requested to have the following forms completed prior to arrival: - current resident roster; - discharge or deceased resident roster; and - employee list (full names, titles, and hire dates). On May 15, 2023, at 10:00 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility. Unlicensed personnel (ULP)-E escorted the surveyor to a room to be used during the survey process. ULP-E informed the surveyor that there was no registered nurse (RN) or licensed practical nurse (LPN) available to meet for the survey. On May 15, 2023, at 10:26 a.m., ULP-E was able to contact LPN-A via phone for entrance conference. During the entrance conference, LPN-A informed surveyor that licensed assisted living director/registered nurse (LALD/RN)-D was currently out of the country and would be unable to attend the survey.	0 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 320	Continued From page 4 On May 15, 2023, at 11:20 a.m., the surveyor requested LPN-A provide the required documents listed in the entrance email within one hour. LPN-A informed surveyor that she would be unable to provide most of requested documents as they were stored at a separate location, and LALD/RN-D had gone with the keys. On May 15, 2023, at 11:40 a.m., ULP-E provided surveyor with some resident and employee records. On May 16, 2023, at 8:30 a.m., the surveyor met with LPN-A who provided the following records to the surveyor: policies and procedures manual and infection control/TB policies and procedures. On May 17, 2023, at 11:25 a.m., following the surveyor's multiple in-person, phone, and email attempts to gather additional information from the licensee to complete the survey, LPN-A again stated the licensee was not able to provide most documentation requested by the surveyor because they were locked up at a separate office location and she was unable to retrieve these documentation as LALD/RN-D was out of the country with the keys. On May 17, 2023, at 2:35 p.m., LPN-A stated licensee would email the surveyor all missed records during the survey by the following week to include: - all resident nursing assessments; - employee training and competency records; - employee supervision records; - annual training records; - licensee quality management program; - emergency preparedness program; - resident contracts; - current resident service plans;	0 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 320	Continued From page 5 - dementia training; - annual training; - employee orientation; - provider orders; - current medication administration records; - blood glucose monitoring records; - catheter care documentation; and - colostomy care documentation. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 320		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to one of two residents (R1). This practice resulted in a level one violation (a	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 450	Continued From page 6 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: R1 admitted to the licensee on September 29, 2022. R1's record lacked evidence the licensee provided the BOR to R1 before initiating services. On May 16, 2023, at 10:20 a.m., licensed practical nurse (LPN)-A stated some resident information was locked in their offsite office, and the registered nurse (RN) responsible was out of the country with the keys. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
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	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 470	Continued From page 7 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. In addition licensee failed to ensure the required 24-hour staffing schedule was posted in a central location. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 470	Continued From page 8 The findings include: On May 15, 2023, at 10:10 a.m., during the entrance conference, licensed practical nurse (LPN)-A stated the licensee had a staffing plan that was evaluated two times per year. In addition, LPN-A stated the licensee's staffing plan included two staff for day, evening, and night shifts to care for the residents. On May 15, 2023, at 11:04 a.m., during the facility tour the surveyor did not observe a 24-hour staffing schedule posted in a central location. At 11:06 a.m., unlicensed personnel (ULP)-E stated their staffing schedule was posted in their online communication forum available only to staff. On May 16, 2023, at 9:53 a.m., LPN-A stated the licensee had a written a staffing plan, but it was locked in their offsite office location and the registered nurse (RN) responsible was out of the country with the keys. 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:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 480	Continued From page 9 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 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 interview and record review, the licensee failed to ensure staff had access to the registered nurse (RN), 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This resulted in an immediate correction order issued on May 16, 2023, at 4:45 p.m. 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,	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 495	Continued From page 10 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Licensed assisted living director (LALD)/RN-D started employment with licensee April 28, 2021, under the comprehensive license and the assisted living license on August 1, 2021. R2's nursing note dated May 8, 2023, indicated R2 was discharged from hospital and arrived at the licensee's facility accompanied by paramedics. R2's Nursing Admission Assessment dated May 8, 2023, indicated R2 was readmitted to the facility after a hospitalization. There was no indication of who completed the assessment. R2's Medication Sign Out Form dated between May 8, 2023, and May 15, 2023, indicated unlicensed personnel (ULP) were responsible to administer medications to R2. R2's record lacked a service plan documenting agreement on the services to be provided. On May 15, 2023, at 10:20 a.m., ULP-E stated none of the licensee's nurses were available to participate in an entrance conference because licensed assisted living director (LALD/RN)-D was out of the country, and licensed practical nurse (LPN)-A was at her other work location. On May 15, 2023, at 10:30 a.m., ULP-E called	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 495	Continued From page 11 LPN-A on the phone to complete the entrance conference. During the entrance conference, LPN-A stated LALD/RN-D was out of the country and would be returning this week. LPN-A also stated LALD/RN-D worked Mondays, Wednesdays, and Fridays. The licensee did not have a staffing plan for determining its staffing level. On May 16, 2023, at 11:38 a.m., LPN-A stated LALD/RN-D left the country on May 8, 2023, and was due to return May 19, 2023. LPN-A also stated ULP were instructed to call her (LPN-A) for assistance if needed. On May 16, 2023, at 11:50 a.m., ULP-B stated she tried to call LALD/RN-D yesterday for personal reasons, but the call would not go through. ULP-B also stated in the absence of LALD/RN-D, they were instructed to reach out to LPN-A in case of any questions. On May 16, 2023, at 12:20 p.m., LPN-A stated R2 was hospitalized as a result of hallucinations and refusing to eat, and was discharged on May 8, 2023. LPN-A completed the readmission assessment because RN-D was not available to reassess R2 upon return. The Licensee's undated, Nursing Assessment and Reassessment of Residents policy indicated RN will reassess the resident any time the resident returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. No further information was provided.	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 495	Continued From page 12 TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-E, ULP-F). In addition licensee failed to ensure a sharps container was provided to discard used sharps safely. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 510	Continued From page 13 affect a large portion or all the residents). The findings include: On May 16, 2023, at 8:17 a.m., the surveyor observed ULP-B prepare breakfast without completion of hand hygiene. On May 16, 2023, at 9:30 a.m., the surveyor observed ULP-B and ULP-C assist R1 to dress and transfer into a wheelchair. ULP-B and ULP-C went directly into another resident's room with the same gloves used in R1's room. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare R1's medication without completion of hand hygiene. On May 17, 2023, at 8:19 a.m., the surveyor observed ULP-E and ULP-F don gloves before washing hands and walk into R1's room to complete blood glucose monitoring. ULP-E completed vital signs and administered medications, then ULP-F administered insulin and discarded the lancet and needle in the trash can in R1's room and proceed into the hallway with same gloves used for cares in R1's room. On May 17, 2023, at 9:40 a.m., ULP-E stated all staff are trained to maintain infection control procedures to ensure infection free work environment. ULP-E also stated the sharps container was in the nursing office, and should be in every resident room with blood glucose checks. On May 17, 2023, at 12:01 p.m., licensed practical nurse (LPN)-A stated all staff are trained on infection control methods and the importance to minimize infection. LPN-A also stated the sharps containers were available, if one was filled	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 510	Continued From page 14 up, the ULP deliver it back to the office and pick up a new one. In addition LPN-A stated the registered nurse (RN) in charge of infection control was out on vacation. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in a Health Care Settings dated November 15, 2022, directed health care workers to wash their hands for at least 20 seconds with soap and water when hands are visibly dirty, before eating, after using restroom, and after caring for people. The U.S. Food and Drug Administration - Safely Using Sharps (Needles and Syringes) at Home, at Work and on Travel dated November 19, 2021, indicated used needles and other sharps are dangerous to people and pets if not disposed of safely because they can injure people and spread infections that cause serious health conditions. Also indicated, never place loose needles and other sharps (those that are not placed in a sharps disposal container) in the household or public trash cans or recycling bins, and never flush them down the toilet. This puts trash and sewage workers, janitors, housekeepers, household members, and children at risk of being harmed. No further information was provided TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 550	Continued From page 15 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all five residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting for the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 550	Continued From page 16 On May 15, 2023, at 11:10 a.m., during a facility tour, the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the grievance procedure. On May 15, 2023, at approximately 11:25 a.m., unlicensed personnel (ULP)-E verified the common areas lacked a grievance procedure posting with required content. On May 16, 2023, at 10:10 a.m., licensed practical nurse (LPN)-A stated the licensee provided each resident with a complaint form upon admission and licensee had not received any grievances. The licensee's undated Complaint and Investigation Process policy indicated residents will be informed of their right to complain to the facility about the services received and of the process to follow when making a complaint to the provider. Residents and their representatives will be informed that complaints may be made without fear of discrimination and/or retaliation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 580	Continued From page 17 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document its quality management activity. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: At the time of the survey, the licensee failed to provide documentation of its quality management program. During the entrance conference on May 15, 2023, at 10:10 a.m., unlicensed personnel (ULP)-E stated the last meeting was held February 2023. He and three other employees attended the meeting. They discussed how to manage medication administration quality, housekeeping, resident activities of daily living, what had been working and not working, and what the licensee needed to improve.	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 580	Continued From page 18 On May 16, 2023, at 11:15 a.m., licensed practical nurse (LPN)-A stated the licensee's quality management meeting notes were locked in their other office, but the registered nurse responsible was out of the country with the keys. The licensee's undated Quality Management Program policy indicated licensee "shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to our residents. All staff will be involved in the implementation of performance improvement activities. Outcome measurement of these activities will be monitored on a continuous basis and all results will be reported, at least annually, to the management team". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 630	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's record lacked an IAPP with required content to include: - review or assessment of the R1's susceptibility to abuse by another individual, including other vulnerable adults; - R1's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 630	Continued From page 20 On May 17, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the IAPP was lacking in R1's record. LPN-A also stated the registered nurse who was responsible for the assessment, and would know if an IAPP was completed, was out on vacation. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated personnel are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse/neglect to that resident. In addition, all facility personnel rendering service to a resident are mandated to report maltreatment or injuries which are not reasonably explained to their supervisor or to the Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 640	Continued From page 21 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC), and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, at 11:20 a.m., during the facility tour, the surveyor observed a cordless phone and charger on the kitchen countertop near a resident common area. In addition, the surveyor observed the facility's main entry area and common areas lacked the required posted information as follows: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 640	Continued From page 22 On May 16, 2023, at 10:27 a.m., licensed practical nurse (LPN)-A stated licensee was not aware of the requirement. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated personnel are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse/neglect to that resident. In addition, all facility personnel rendering service to a resident are mandated to report maltreatment or injuries which are not reasonably explained to their supervisor or to the Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 660	Continued From page 23 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated June 24, 2020, indicated the licensee was low risk. The licensee failed to update and complete a TB risk assessment annually. ULP-B ULP-B started employment with licensee January 3, 2023, to provide assisted living services. ULP-B's employee record lacked the following required content: - Baseline TB screening to include: assessing for current symptoms of active TB disease,	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 660	Continued From page 24 assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test; and - TB education. On May 16, 2023, at 12:40 p.m., ULP-B stated they completed a TB blood test and sent the results to registered nurse (RN)-D. ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services. ULP-F's employee record include a Baseline TB Screening Tool for Healthcare Workers (HCWs) incomplete form dated February 3, 2023. ULP-F's employee record lacked the following required content: - Baseline TB screening to include: assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test; and - TB education. On May 17, 2023, at 11:05 a.m., licensed practical nurse (LPN)-A stated ULP-B and ULP-F's employee records did not include the above required TB content. Additionally, LPN-A stated licensee could not access additional records in their other office, because licensed assisted living director/registered nurse (LALD/RN)-D locked it and went with the key on vacation.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 660	Continued From page 25 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with residents must have documentation of baseline health screening prior to providing care to residents. This includes, at a minimum, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on agency risk assessment or a negative IGRA (blood test). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 680	Continued From page 26 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 maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 680	Continued From page 27 The licensee's undated binder with blank documents intended to be customized EP plan lacked the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGININEERING); and - Integrated Health Systems; On May 16, 2023, at 1:15 p.m., licensed practical nurse (LPN)-A stated the licensee's EP plan was missing required information. LPN-A also stated the registered nurse who was responsible for the EP plan and would know if more information was available was out on vacation. No further information was provided.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER

UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 680	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record 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;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 29 (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 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 observation, interview, and record review, the licensee failed to document for services provided as identified in the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 30 monitoring. On May 16, 2023, at 11:30 a.m., the surveyor observed ULP-B assist home care nurse change R1's wound dressings. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose and later empty the colostomy bag. R1's Home Health Aide Care Plan dated September 29, 2022, indicated ULP's to empty R1's colostomy and Foley catheter bags at end of every shift and as needed. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: colostomy care, wound care, catheter care, ostomy care, and blood glucose monitoring three times daily. R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. R1's record lacked documentation for services provided to include the date and time of service, the signature and title of the person who completed the service. When services are not provided as ordered or prescribed, the provider must document the reason why it was not provided and any follow-up procedures that were provided to meet the resident's needs. On May 17, 2023, at 11:30 a.m., ULP-F stated all services provided are documented in the computer and on paper.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 31 On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident record was locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 780	Continued From page 32 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms, failed to provide smoke alarms outside and in the immediate vicinity of all sleeping areas, and failed to provide smoke alarms that were interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: A facility tour was conducted on May 17, 2023, between approximately 9:15 a.m. and 10:15 a.m., with the unlicensed professional (ULP)-E. Survey staff and ULP-E were joined by the licensed practical nurse (LPN)-A at approximately 9:30 a.m. on the tour. It was observed that bedroom #2 and bedroom #3 did not have a smoke alarm installed. ULP-E stated that the licensee had removed the smoke alarms to install new batteries and hadn't put them back into place. ULP-E could not locate the smoke alarm for bedroom #2 but was able to find	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 780	Continued From page 33 the smoke alarm for bedroom #3 on top of the dresser, under a pile of the resident's clothing. It was observed that there was no smoke alarm outside and in the immediate vicinity of bedroom #3. The closest smoke alarm was in the hallway which was separated by a deep bulkhead and long distance. The smoke alarm in the hallway, outside bedrooms #4 and #5 did not work when tested. ULP-E stated that the batteries needed to be changed. It was observed upon testing that the smoke alarms in the facility were not interconnected so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. These deficient conditions were visually verified by LPN-A and ULP-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 790	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide adequately rated portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A facility tour was conducted on May 17, 2023, between approximately 9:15 a.m. and 10:15 a.m., with the unlicensed professional (ULP)-E. Survey staff and ULP-E were joined by the licensed practical nurse (LPN)-A at approximately 9:30 a.m. on the tour. It was observed that each of the fire extinguishers provided were 1-A:10-BC rated, and the licensee did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. ULP-E visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 35	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 36 licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 17, 2023, at approximately 10:45 a.m. with the unlicensed professional (ULP)-E and the licensed practical nurse (LPN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. The licensee stated that the fire safety and evacuation documentation was not at the facility and could not be emailed to survey staff as the person who manages the policies was currently out of the country. The licensee did not have employee actions to be taken in the event of a fire or similar emergency included in the fire safety and evacuation plan. During interview, LPN-A and ULP-E verified that they did not know if the fire safety and evacuation plan for the facility included these provisions. The licensee did not have fire protection procedures necessary for residents included in	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 37 the fire safety and evacuation plan. During interview, LPN-A and ULP-E verified that they did not know if the fire safety and evacuation plan for the facility included these provisions. The fire safety and evacuation plan did not include 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. During interview, LPN-A and ULP-E verified that they did not know if the fire safety and evacuation plan for the facility included these provisions. The licensee did not provide any documentation of employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LPN-A and ULP-E stated the licensee did not have any documented training and they did not know what the policy was on training employees. The licensee did not provide any documentation of annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, LPN-A and ULP-E stated the licensee did not have any documented training and they did not know what the policy was on training residents. The licensee did not provide documentation that they conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LPN-A and ULP-E stated the licensee did not have any documented evacuation drills and they did not know what the policy was on conducting evacuation drills.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	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 bedroom # 2 with the minimum window opening meeting the minimum state standard for egress. Licensee also failed to provide fire-rated ashtrays for resident use in smoking areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 820	Continued From page 39 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: A facility tour was conducted on May 17, 2023, between approximately 9:15 a.m. and 10:15 a.m., with the unlicensed professional (ULP)-E. Survey staff and ULP-E were joined by the licensed practical nurse (LPN)-A at approximately 9:30 a.m. on the tour. It was observed that the egress window in unoccupied bedroom #2 was obstructed by a window air conditioning unit. Survey staff was unable to open the window in resident bedroom #2 on the main floor for measurement. The dimensions of the windowpanes of the double-hung window were 34 inches in width and 17 inches in height. Survey staff explained to LPN-A and ULP-E that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LPN-A and ULP-E verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20" and minimum openable height of 20" with no less than 648 square inches total of openable area (4.5 square feet) for the window. It was observed that the wooden deck area and the main entrance, located under a breezeway, were being used as smoking areas. The main entrance is immediately adjacent to the only window for resident bedroom #2 and was not	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 820	Continued From page 40 provided with a fire-rated ashtray. The wooden deck was off the kitchen area and was not provided with a fire-rated ashtray. ULP-E stated that residents smoked on the deck or under the breezeway and used loose pieces of tinfoil as an ashtray. Survey staff observed a resident smoking by the main entrance with a piece of tinfoil resting on his chest where he was ashing his cigarette. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if residents' cigarettes were not completely extinguished before discarding them. ULP-E verbally confirmed the findings. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 900 SS=D	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	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 900	Continued From page 41 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 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 develop and execute a written contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 900	Continued From page 42 catheter care, colostomy care, and blood glucose monitoring. R1's record lacked a written Assisted Living contract to include the required content executed with the resident prior to providing assisted living services. On May 17, 2023, at 10:40 a.m., licensed practical nurse (LPN)-A stated R1's contract was not in R1 resident record folder. Additionally, LPN-A stated an extra copy would be in licensee's other office but could not access it as licensed assisted living director/registered nurse (LALD/RN)-D locked the office and went the key on vacation. The licensee's undated Assisted Living Contracts policy indicated licensee will establish a contract with each resident at the time of admission to the program. The contract will be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents will receive an unsigned copy of the contract and an unsigned copy will be provided for the Office of the Ombudsman for Long-Term. Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 43 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 offer the residents the opportunity to identify a designated representative in writing in the contract. In addition, licensee failed to provide the required verbatim notice on a document separate from the contract for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 44 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: R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's unsigned Resident Contract for Assisted Living dated December 8, 2022, had a section on the first page titled Designated Representative which was blank, the contract also lacked the required verbatim notice. On May 17, 2023, at 11:07 a.m., licensed practical nurse (LPN)-A stated they thought the contract was completed with all required content. LPN-A also stated licensee was not aware of resident designation of representative, hence none of the residents would have a designated representative. The licensee's undated Assisted Living Contracts policy indicated licensee will establish a contract with each resident at the time of admission to the program. The contract will be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents will receive an unsigned copy of the contract and an unsigned copy will be provided for the Office of the Ombudsman for Long-Term Care.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01060	Continued From page 46 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 the required content for an emergency relocation to the resident, legal representative, or designated representative, for two of two residents (R2, R5) and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of two residents (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) 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: R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's Service Plan dated December 7, 2022, indicated R2 received services including	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01060	Continued From page 47 medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's nursing progress note dated May 8, 2023, at 1:00 p.m., indicated R2 was received back to licensee after a hospital stay. On May 8, 2023, at 1:05 p.m., the licensed practical nurse (LPN)-A stated they could not remember when R2 was sent to hospital, neither could they find a written nursing note. R2's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. R5 R5 was admitted to licensee on February 1, 2023, for assisted living services. R5's progress note dated May 2, 2023, indicated R5 had an uncontrolled pulse which necessitated the licensee to send R5 to hospital. On May 15, 2023, at the time of the survey, R5 still remained in the hospital 13 days later. R5's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The licensee also failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required. On May 16, 2023, at 1:15 p.m., LPN-A stated the licensee had not provided to the resident, resident's representative or to the ombudsman's office the required notices for emergency relocation as the licensee was not aware of the	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01060	Continued From page 48 requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to staff providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01290	Continued From page 49 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E started work at the licensee's facility on January 31, 2022. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare and check blood glucose and administer medications to R1. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. On May 17, 2023, at 9:00 a.m., the surveyor observed ULP-F administer medications to R1. On May 16, 12:30 p.m., the NetStudy 2.0 website indicated ULP-B, ULP-E, and ULP-F were cleared and affiliated to licensee's active comprehensive home care license under the same ownership as the licensee. On May 16, 2023, at 2:30 p.m., licensed practical nurse (LPN)-A stated ULP-B, ULP-E, and ULP-F's background studies were in another of licensee's office but could not access it, as it was	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01290	Continued From page 50 locked, and licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Background Studies policy indicated licensee requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Unwillingness to consent to the background study will result in withdrawal of the offer of employment. Results of the background studies are confidential and are retained in confidential employee files. Employees will not be able to start working with residents until the background check clearance has been received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01330	Continued From page 51 (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee training and competency was completed, to include all required content, for three of three employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. On May 16, 2023, at 9:45 a.m., the Nursing Assistant Registry website indicated ULP-B had a current certification with an expiration date October 10, 2023. ULP-B's employee record lacked competencies to include the following: - appropriate and safe techniques in personal hygiene and grooming, including:	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01330	Continued From page 52 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the client; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. ULP-E ULP-E started work at the licensee's facility on January 31, 2022. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-E prepare and check blood glucose and administer medications to R1. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. ULP-E, and ULP-F's employee records lacked training and competency evaluation to include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01330	Continued From page 53 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Qualification, Training and Competency policy indicated licensee shall provide training to all staff providing and supervising assisted living services at the time of	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01330	Continued From page 54 hire, and as needed to meet state guidelines and quality standards. Also indicated all staff members must be competent in the provision of services consistent with current practice standards appropriate to the resident's need and support the assisted living bill or rights. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
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 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.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01440	Continued From page 55 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the task was delegated for two of two unlicensed personnel ((ULP)-B, ULP-F). 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-F prepare and check blood glucose and administer medications to R1. ULP-B and ULP-F's employee record lacked documentation of supervision within 30 calendar days after the date medication administration and treatment tasks were delegated.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01440	Continued From page 56 On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Supervision of Unlicensed Personnel policy indicated licensee shall provide personal care and supportive services by unlicensed personnel under the direction and supervision of a registered nurse or other licensed health professional. Also indicated ULP shall be supervised periodically where the services are being provided to verify the work is performed competently and to identify problems and solutions related to staff ability to provide the care. No further information was 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01470	Continued From page 57 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 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,	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01470	Continued From page 58 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 orientation to assisted living facility licensing requirements before providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-F), 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 ULP-B started work at the licensee's facility on January 3, 2023. On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-B administer medications to R2. ULP-B employee record included undated and unsigned Staff Orientation Outline and Sign-Off which indicated licensee was using outdated Orientation to Home Care Requirements instead of assisted living (AL). ULP-F ULP-F started work at the licensee's facility on February 3, 2023.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01470	Continued From page 59 On May 17, 2023, at 8:11 a.m., the surveyor observed ULP-F prepare and check blood glucose and administer medications to R1. ULP-B and ULP-F's employee records lacked orientation in the following AL topics: - 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; - Assisted Living bill of rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principles of person-centered planning/service delivery; and - Orientation to each specific resident and services provided [144G.63 Subd. 3]. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Facility Employee Orientation policy indicated all employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the Facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01470	Continued From page 60 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01500	Continued From page 61 (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. 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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01500	Continued From page 62 only occasionally). The findings include: ULP-E started work at the licensee's facility on January 31, 2022. ULP-E's employee record lacked annual training for at least eight hours of annual training for each 12 months of employment in the following topics: - training on reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights; - review of infection control techniques; - review of the facility's policies and procedures. - review of person-centered planning/service delivery; and - added 2 hours of dementia training. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01530	Continued From page 63 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 all staff received eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-B, ULP-F). 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01530	Continued From page 64 of the residents). The findings include: ULP-B ULP-B started work at the licensee's facility on January 3, 2023. ULP-F ULP-F started work at the licensee's facility on February 3, 2023. ULP-B and ULP-F's employee records lacked at least eight hours of initial dementia training on 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. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated all missing employee records were locked up in another office location, but LPN-A did not have access as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01530	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
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 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 the registered nurse (RN) completed a comprehensive nursing assessment within the required timeframe for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01610	Continued From page 66 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: R1 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R1 and R2's records lacked Initial RN assessments by a registered nurse of the physical and cognitive needs of the prospective resident to propose a temporary service plan prior	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01610	Continued From page 67 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. On May 17, 2023, at 1:45 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the licensee will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Also indicated Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01620	Continued From page 68 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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 a comprehensive nursing assessment within the required timeframe for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01620	Continued From page 69 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's nursing note dated May 8, 2023, indicated R2 was discharged from the hospital and arrived at the licensee's facility accompanied by paramedics. R2's Nursing Admission Assessment dated May 8, 2023, indicated R2 was readmitted to the facility after a hospitalization. There was no indication of who completed the assessment, and it lacked to cover the uniform assessment tool content as required.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01620	Continued From page 70 R1 and R2's records lacked reassessment and monitoring conducted no more than 14 calendar days after initiation of services, and ongoing resident reassessment and monitoring 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. On May 17, 2023, at 1:45 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the licensee will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Also indicated Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 71 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 72 The findings include: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On May 17, 2023, at 11:06 a.m., licensed practical nurse (LPN)-A verified R1's record lacked a signed service plan. LPN-A stated R1 could not sign any document because he had encephalitis which had affected his limbs. LPN-A also stated licensee had a conversation with R1's case worker regarding signing documents, and reached agreement that R1's documents could remain unsigned. The surveyor requested documentation of the agreement with the case worker, but LPN-A stated licensed assisted living director (LALD/RN)-D who would know if this agreement was documented had traveled for vacation. The licensee's undated Service Plan indicated the service plan would be signed and dated when updated and/or revised by the resident and/or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 73 resident representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01730	Continued From page 74 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01730	Continued From page 75 2022, indicated R1 received services to include medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated R1 received medications on various dates. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 was taking the following medications, not all included: zinc gluconate 50 milligram (mg) tablet take one-half tablet by mouth once daily for open wound of buttocks, cholecalciferol (vitamin D3) 5,000 units tablet take one tablet (5,000 units by mouth once a day, polyethylene glycol 17 gram (g) per dose powder mix one scoop (17 g) in liquid then take by mouth twice dally, tamusulosin 0.4 mg capsule take one capsule by mouth every day after meal, acetaminophen 325 mg tablet take two tablets (650 mg) by mouth every six hours if needed for pain maximum dose 4000 mg in 24 hours, baclofen 20 mg tablet (Lioresal) take two tablets (40 mg) by mouth three times daily, Basaglar KwikPen (u-100) insulin 100 units/ml (3 ml) pen(glargine) Inject 8 units subcutaneous at bedtime, insulin Aspart (u-100) 100unlts/ml (3 ml) pen (Novolog Flex Pen) inject 0-6 units subcutaneous three times a day with meals per sliding scale. R2 R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01730	Continued From page 76 R2's Service Plan dated December 7, 2022, indicated R2 received services to include medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. R2's Medication Sign out Form dated between May 8, 2023, through May 15, 2023, indicated R2 received medications on various dates. R2's unsigned Physician Order form indicated R2 was taking the following medications: ammonium lac 12% lotion 225 gm topical apply to both feet twice a day, acetaminophen 325 mg tablet take two tablets by mouth every four hours as needed pain or fever, clonidine 0.1 mg tablet take one tablet by mouth every night at bedtime, bupropion hcl 300 mg xl tablet take one tablet by mouth daily, vitamin D3 1,000 unit capsule take two capsules (2000 units) by mouth daily, and duloxetine 30 mg capsule take one capsule by mouth twice a day. R1 and R2's records lacked an individualized medication management record with required content to include: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER: UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 7333 DUPONT AVENUE NORTH, BROOKLYN PARK, MN 55444

(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
01730	Continued From page 77 - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director (LALD/RN)-D had traveled out of the country with the keys. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	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.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01750	Continued From page 78 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) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel demonstrated the ability to competently follow the procedures for two of two employees (unlicensed personnel (ULP)-B, ULP-F). This practice 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 ULP-B started employment with licensee January 3, 2023, to provide assisted living services including medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. On May 16, 2023, at 9:00 a.m., ULP-B stated RN-D trained her to pass medications, and she followed another ULP for two weeks before starting to administer medication on her own. ULP-B also stated the pharmacy sets up all medications in blister packs. R2's Medication Sign out Form dated between May 8, 2023, through May 15, 2023, indicated ULP-B administered medications on various	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01750	Continued From page 79 dates. ULP-B's employee record lacked training or competency testing on medication administration. ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services including medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed ULP-F administer medications to R1. On May 17, 2023, at 9:35 a.m., ULP-F stated RN-D trained him, and he followed another ULP. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated ULP-F administered medications on various dates. ULP-F's employee record lacked training or competency testing on medication administration. On May 17, 2023, at 12:30 p.m., licensed practical nurse (LPN)-A stated all licensee's training and competency testing was completed during orientation of new employees. LPN-A stated if there were any additional records, then licensed assisted living director/registered nurse (LALD/RN)-D would be in a better position to provide them, but was out on vacation. The licensee's undated Medication Management Services policy indicated "the RN will develop and implement medication training curriculum and competency evaluations to assure that licensed and unlicensed staff are trained and competent to perform all delegated medication management tasks".	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01750	Continued From page 80 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 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 the resident's medication administration was documented in the resident's record and the documentation included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01760	Continued From page 81 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1 R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services to include medication administration. On May 17, 2023, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's Medication Sign out Form dated between May 1, 2023, through May 16, 2023, indicated R1 received medications on various dates, but the form only gave the date, the time, number of medications administered, and the initials of person administering medications. R2 R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services to include medication administration. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. R2's Medication Sign out Form dated between	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01760	Continued From page 82 May 8, 2023, through May 15, 2023, indicated R2 received medications on various dates, but the form only gave the date, the time, number of medications administered, and the initials of person administering medications. On May 16, 2023, at 8:20 a.m., when the surveyor inquired how the ULP knew what medications they had administered, ULP-B stated they were to trained to document like that, and the medication names and times were on the blister packs. R1 and R2's medication administration record (MAR) lacked the following content: - the signature and title of the person who administered the medication; - the medication name; - the medication dosage; and - method and route of administration. On May 17, 2023, at 10:45 a.m., licensed practical nurse (LPN)-A stated licensee preferred their documentation as it was easy and avoided medication errors. Further, LPN-A stated all medication names and times were printed on the blister packs and all ULP's were aware. The licensee's undated Documentation of Medication Administration policy indicated staff will refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. The profile or the MAR will also tell staff what side effects or problems to watch for and report. Also indicated to document the medication reminder or administration, initial the appropriate box (or enter electronically) on the MAR form to verify the medication has been	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01760	Continued From page 83 administered at the appropriate time and date. All staff administering medications to a resident must include the staff person's name/initials and title in the signature box on the MAR or applicable authentication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee on December 8, 2022, for assisted living services.	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01830	Continued From page 84 R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's record included unsigned Physician Order form dated December 1, 2022, indicated R2 was taking the following medications: ammonium lac 12% lotion 225 gm topical apply to both feet twice a day, acetaminophen 325 mg tablet take two tablets by mouth every four hours as needed pain or fever, clonidine 0.1 mg tablet take one tablet by mouth every night at bedtime, bupropion hcl 300 mg xl tablet take one tablet by mouth daily, vitamin D3 1,000 unit capsule take two capsules (2000 units) by mouth daily, and duloxetine 30 mg capsule take one capsule by mouth twice a day. R2's record lacked prescriptions renewed at least every 12 months or more frequently as indicated by the assessment. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing resident records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Medication Prescriptions & Refills indicated RN is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01830	Continued From page 85 medications and dietary supplements, are addressed in the resident's care plan, service plan and Medication Administration Record, and are communicated to all appropriate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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 and interview, the licensee failed to 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 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:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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 86 On May 17, 2023, at 11:35 a.m., the engineering surveyor found multiple medications stored in a closet in an unoccupied bedroom within the facility. The door to the bedroom was unlocked and the medications were in small plastic bins on the shelf of a closet. Pictures of medications were obtained. On May 17, 2023, at 12:30 p.m., licensed practical nurse (LPN)-A stated licensee was aware of the medications being stored inappropriately in the vacant room. LPN-A stated the medications were not used and that they were intended for disposition, but licensee had not done it. The licensee's undated Medication Disposition or Disposal policy indicated licensee will develop policies to be followed in disposing of medications that are no longer used or after the resident has been discharged or has died. Facility staff will have guidelines to follow and will contact RN if there are questions or concerns. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	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.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01910	Continued From page 87 (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 by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all the required content one of two discharged residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 discharged from the licensee on December 10, 2022. R3's Hourly Nursing Services Progress Note dated December 10, 2022, indicated R3 died in her room, and hospice nurse coordinated transfer to the morgue.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01910	Continued From page 88 R3's record lacked a medication disposition record with required record to include: - 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. On May 16, 2023, at 10:10 a.m., licensed practical nurse (LPN)-A stated R3 received medication administration services, but R3's record was locked in another office location and LPN-A could not access it as licensed assisted living director (LALD/RN)-D had traveled with the keys. LPN-A also stated all medications are disposed and signed off by two people. The licensee's undated Medication Disposal policy indicated licensee will develop policies to be followed in disposing of medications that are no longer used or after the resident has been discharged or has died. Facility staff will have guidelines to follow and will contact RN if there are questions or concerns. The policy also indicated all the missing content will be included in resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01940	Continued From page 89 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan (ITMP) to include all required content for one of one resident (R1). This practice resulted in a level two violation (a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01940	Continued From page 90 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: R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: wound care and blood glucose monitoring three times daily. R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01940	Continued From page 91 On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose. R1's ITMP lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 17, 2023, at 11:40 a.m., licensed practical nurse (LPN)-A stated licensee's nurse was responsible for daily wound care, and thought the document they used was sufficient. LPN-A also stated was not sure if licensee had any further documentation other than what was provided. The licensee's undated Treatment and Therapy Management Plan policy indicated the individualized plan for each resident receiving treatment or therapy services will be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. The policy also indicated the missing content above will be included.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01940	Continued From page 92 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01950	Continued From page 93 procedure for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following treatments: blood glucose monitoring three times daily. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received. ULP-F ULP-F started employment with licensee February 3, 2023, to provide assisted living services including delegated treatments. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F check R1's blood glucose. On May 17, 2023, at 9:00 a.m., ULP-F stated he only remembered following another ULP for about two weeks before starting to provide cares. ULP-F's records lacked information RN had	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01950	Continued From page 94 instructed in the proper methods with respect to each resident and ULP-F had demonstrated the ability to competently follow the procedures. On May 17, 2023, at 2:15 p.m., licensed practical nurse (LPN)-A stated all missing records were locked up in another office location, but LPN-A did not have access to it as licensed assisted living director/registered nurse (LALD/RN)-D had traveled out of the country with the keys. The licensee's undated Treatment and Therapy Management Plan policy indicated when administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse or authorized licensed health professional has: - instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedure; - specified in writing detailed instructions for each resident and documented the instructions in the resident's record; and - communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01970	Continued From page 95 provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development, and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring. R1's provider unsigned Home Health Certification and Plan of Care dated January 16, 2023, for the period starting January 29, 2023, through March 28, 2023, indicated R1 received the following	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
01970	Continued From page 96 treatments: blood glucose monitoring three times daily. R1's unsigned after visit summary dated May 10, 2023, indicated change wound dressing twice daily. On May 17, 2023, at 8:20 a.m., the surveyor observed ULP-F prepare and check R1's blood glucose and later empty the colostomy bag. R1's record lacked an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies R1 received. On May 17, 2023, at 11:20 a.m., licensed practical nurse (LPN)-A stated licensee was using the after-visit summary as R1's current orders. LPN-A also stated if there were other orders licensed assisted living director (LALD/RN)-D would best answer, but LALD/RN-D was out of the country on vacation. The licensee's undated Treatment and Therapy Management Plan policy indicated orders must be obtained for medications, treatments or therapies that would require orders from an authorized provider before the services are provided. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
02310	Continued From page 97 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for two of two residents (R1 and R2) who utilized bed rails. This resulted in an immediate correction order issued on May 17, 2023, at 1:30 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on September 29, 2022, for assisted living services. R1's diagnoses included acute encephalitis, type 2 diabetes mellitus, hypertension, neurogenic bladder, disorder of intellectual development and open wound of buttock with complications. R1's unsigned Service Plan dated September 28, 2022, indicated R1 received services including medication administration, treatment, Foley catheter care, colostomy care, and blood glucose monitoring.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
02310	Continued From page 98 On May 16, 2023, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B, and ULP-C transfer R1 from the bed into his power wheelchair. R1's hospital bed had bilateral rectangular bed rails measuring approximately 32 inches long by 15 inches tall. The middle space of the bed rail had 10 vertical bars which were about four inches apart. R1's record lacked the following bed rail information: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion; - the resident's preferences; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R2 R2 was admitted to the licensee on December 8, 2022, for assisted living services. R2's diagnoses included excessive obesity, lymphedema, urinary retention, amblyopia, and hyperthyroidism. R2's Service Plan dated December 7, 2022, indicated R2 received services including medication administration, treatment, bathing assistance, dressing assistance, and positioning/transfer. R2's Side-Rail Use Assessment Form dated December 8, 2022, indicated R2 used a side rail to promote independence. On May 17, 2023, at 12:03 p.m. the surveyor and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	37041		05/17/2023

NAME OF PROVIDER OR SUPPLIER
UNITY TRUST HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

(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
02310	Continued From page 99 unlicensed personnel (ULP)-E observed R2's hospital bed had bilateral rectangular bed rails measuring approximately 30 inches long by 12 inches tall. The middle space of the bed rail had three vertical bars and two horizontal bars which divided the bed rail into six open spaces and about four inches apart. R2's record lacked the following bed rail information: - measurements; - risk vs. benefits discussion; - the resident's preferences; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On May 17, 2023, at 12:26 p.m., licensed practical nurse (LPN)-A stated she was unaware of the required documentation because the registered nurse (RN) managed it. LPN-A further stated the information was in a different location, and she did not have access to it. The licensee's undated, Use of Side Rails policy indicated side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. No further information was provided TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *05/17/23*
Time: 11:10:00
Report: 1018231090

Food and Beverage Establishment Inspection Report

Location:
Unity Trust Home Care
7333 Dupont Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0038585
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633165336
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE.

Corrected on Site

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 ON SITE. CFPM INFORMATION SENT TO MANAGER.

Comply By: 08/31/23

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED WITH BENARD NYANGENA (MDH) PRESENT.

FACILITY HAS DISHWASHER WITH SANITIZING FUNCTION AVAILABLE.

ALL FOOD IS SAME DAY SERVICE.

FACILITY HAS A SEPARATE SINK FOR HAND WASHING.

DISCUSSED EMPLOYEE ILLNESS AND PEST CONTROL.

PHYSICAL FACILITIES OBSERVED IN GOOD REPAIR.

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 1018231090 of 05/17/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
FLORENCE WISIKE
MANAGER

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us