Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF PROVISIONAL CONDITIONAL LICENSE

Electronic Delivery

February 27, 2025

Licensee
Lyngblomsten at Lino Lakes LLC
6050 Blanchard Boulevard
Lino Lakes, MN 55014

RE: Initial License Number 413350
Health Facility Identification Number (HFID) 40167
Project Number(s) SL40167015

Dear Licensee:

On February 4, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 11, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 27, 2025.

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

Effective, February 27, 2025, MDH is granting your Assisted Living Facility with Dementia Care facility license. Your license effective and expiration dates remain the same as on your provisional license. Your license number is 842903370. <u>You will not receive a replacement license certificate until your license is due to renew</u>. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.assistedliving@state.mn.us.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 11, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 11, 2024, found not corrected at the time of the follw-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1880-Storage Of Medications-144g.71 Subd. 19

The details of the violations noted at the time of this follow-up survey completed on February 4, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40167	A. BUILDING: _____ B. WING _____	R 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL40167015-1 On February 4, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 11, 2024. At the time of the survey, there were 44 residents; 42 receiving services under the Assisted Living License. As a result of the follow-up survey, 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	{0 800}		

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{0 800}	Continued From page 2 repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	{0 810}		

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{0 810}	Continued From page 3 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was secured in a locked area for one of two residents (R7). 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: R7 was admitted to the licensee on February 21, 2024, and resided in the licensee's secured dementia care unit.	{01880}		

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{01880}	Continued From page 4 R7's [licensee] Master Assessment Tool dated November 15, 2024, read under Section 6. Medication Management, "non-controlled medications are stored in locked cabinet in resident's room. Access limited to staff responsible for managing or administrating medications." Additionally, the assessment indicated R7 received oral medications only. R7's [licensee] Service Plan with effective date of February 4, 2025, was identified by clinical nurse supervisor (CNS)-B as R7's current implement service plan, indicated R7 required medication management services. On February 4, 2025, at 8:20 a.m., the surveyor observed the following over-the-counter (OTC) medications on R7's bathroom counter and in R7's bathroom cabinet: - Open bottle of aspirin 81 mg; - Open bottle of antacids; - Open container of fleet suppositories; - Open bottle of nasal spray; - Open container of medicated chest rub. On February 4, 2025, at 11:10 a.m., CNS-B stated the OTC medications should not be in R7's room and all medications for every resident in licensee's dementia care unit should be secured in a locked cabinet. CNS-B stated R7 had medications in their room on the initial survey which were removed at that time, but R7 must have had someone bring the OTC meds to them without staff's knowledge. The licensee's 2024 Plan of Correction indicated licensee had educated staff to report unsecured medications to nurse, educated families on proper storage of medications, and performed	{01880}		

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{01880}	Continued From page 5 ongoing monthly audits of resident's rooms. The licensee's Storage of Medications policy dated July 2023, indicated medications would be stored based on the registered nurse assessment and as manufacturer's directions. No further information provided.	{01880}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

November 25, 2024

Licensee
Lyngblomsten at Lino Lakes, LLC
6050 Blanchard Boulevard
Lino Lakes, MN 55014

RE: Provisional Conditional License Number 413350
Health Facility Identification Number (HFID) 40167
Project Number(s) SL40167015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 11, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90 days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **February 23, 2025**.

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,500.00. **MDH is not imposing**

these fines against your provisional license at this time.

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

b. **No new admissions:** Lyngblomsten at Lino Lakes, LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the

"no new admissions" condition. Lyngblomsten at Lino Lakes, LLC must provide the Department:

i. A list of the names and birthdates of any individuals Lyngblomsten at Lino Lakes, LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

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

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Lyngblomsten at Lino Lakes, LLC and the RN consultant about a change. Each report will be electronically submitted to Brandon Mueller, at Brandon.W.Mueller@state.mn.us. Brandon Mueller can be reached at 651-247-2064 (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 the Department or considered important by the RN consultant(s).

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

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

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Lyngblomsten at Lino Lakes, LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Lyngblomsten at Lino Lakes, LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Lyngblomsten at Lino Lakes, LLC. If MDH determines Lyngblomsten at Lino Lakes, LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

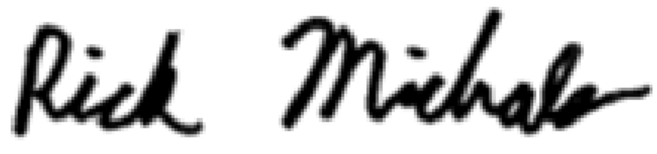
REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Brandon Mueller directly at: 651-247-2064.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40167	A. BUILDING: _____ B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40167015-0 On October 7, 2024, through October 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 24 residents; 24 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

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0 510	Continued From page 1 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 ensure infection control standards were followed for one of two employees, (unlicensed personnel/ULP-G) during medication administration. 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 October 9, 2024, at 7:50 a.m., the surveyor observed ULP-G donn (put on) disposal gloves, complete morning medication administration for R11 and remove disposable gloves. ULP-G proceeded to R12's room. The surveyor did not observe ULP-G complete handwashing before donning gloves or after removing gloves, or in	0 510		

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0 510	Continued From page 2 between residents. On October 9, 2024, at 8:00 a.m., the surveyor observed ULP-G donn disposal gloves, complete morning medication administration for R12 and removed disposable gloves. The surveyor did not observe ULP-G complete handwashing before donning gloves and after removing gloves. On October 9, 2024, at 8:10 a.m., ULP-G stated ULP-G normally washes her hands in between resident and between glove changes but did not during the above observations. On October 9, 2024, at 8:20 a.m., clinical nurse supervisor (CNS)-B stated expectations for handwashing include before donning and removal of gloves, as well as in between resident cares. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated July 2023, indicated unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the registered nurse (RN) on the following: infection control precautions that must be followed when administering medications, treatment and therapy. The licensee's Procedure for Using Gloves, dated July 2023, indicated to wash hands before applying gloves to both hands, and dispose of used gloves in proper receptacle-biohazard if they have contaminated material on them and rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 3 days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including a completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-G). This practice resulted in a level two 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 an	0 660		

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0 660	Continued From page 4 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment was completed on August 15, 2023, and the facility was determined to be a low risk level. ULP-G was hired on August 13, 2024, to provide direct care services to the licensee's residents, ULP-G's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs) dated August 13, 2024, which indicated ULP-G had a first step of a TST with a negative result on August 16, 2024. ULP-G's employee record lacked evidence of a completion of a two-step TST or other evidence of TB screening such as a blood test. On October 10, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B verified the second step of the TST was not in her records. CNS-B stated the second step must have been missed and did not get completed. The licensee's 8.0 TB Prevention and Control policy dated July 2023, indicated upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is a potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. If the first step of the two step TST is negative the employee may begin working with residents (if the TST is dated within 90 days	0 660		

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0 660	Continued From page 5 before hire) but must have the second TST test within 21 days after hire. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. 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 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	0 680		

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0 680	Continued From page 6 (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 observation and interview, the licensee failed to provide the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as part of the emergency plan to ensure the proper performance of the generator. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 8, 2024, at 10:45 a.m., survey staff toured the facility with maintenance director (MD)-D. During the facility tour interview on October 8, 2024, MD-D verified the facility had an emergency power generator and stated weekly	0 680		

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0 680	Continued From page 7 generator inspections were performed but these had not been recorded and monthly tests had not been performed. MD-D stated a service provider was scheduled to complete annual generator testing. The licensee failed to provide the minimum frequency of inspections, maintenance, and load tests to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: -Records for weekly inspections of the generator systems were not provided. -Monthly load test records were not provided. -No records of monthly transfer switch operation tests were provided. TIME PERIOD FOR CORRECTION: Seven (7 days)	0 680		
0 730 SS=D	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,	0 730		

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0 730	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required	0 730		

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0 730	Continued From page 9 content for one of one resident (R3) discharged from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Discharge Resident Roster, dated October 7, 2024, indicated R3 was admitted to the facility on February 13, 2024, and was discharged on September 24, 2024. R3's diagnoses included vascular dementia, diabetes, and hypertension (HTN). R3's service plan dated February 12, 2024, indicated R3 received medication administration, laundry, and housekeeping. R3's Progress Notes dated September 24, 2024, at 11:34 a.m., written by registered nurse (RN)-F indicated R3 was discharged from the community today at 11:00 a.m., resident moving to [facility], transported by son. Medications given to spouse [name]. Mover will arrive at 12:00 p.m. to remove personal belongings. Primary care provider updated pharmacy notified. R3's record lacked a discharge summary. On October 8, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated there was no other discharge information in R3's record and was	0 730		

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0 730	Continued From page 10 unsure why it was not completed. The licensee's NUR-3.0 Resident Record policy dated July 2023, indicated records are maintained for each resident for whom the facility provides services to include a discharge summary, including service termination and related documentation when applicable. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. A. A summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results. B. A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status. C. A reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over-the-counter medications. D. A post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and non-medical services the resident would need.	0 730		

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0 730	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 800		

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0 800	Continued From page 12 On October 8, 2024, at 10:45 a.m., survey staff toured the facility with maintenance director (MD)-D. During the tour, the surveyor observed the following: - The labeled 90-minute fire door for the basement storage room was held open by a wedge. - The labeled 20-minute fire door for resident room 241 was held open by a wedge. - The labeled 20-minute fire door for the employee office in the dementia care unit was held open with a wedge. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. During the facility tour interview on October 8, 2024, MD-D verified these fire doors were not properly maintained as designed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 13 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 8, 2024, maintenance director (MD)-D and licensed assisted living director (LALD)-A provided documents on the fire safety	0 810		

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0 810	Continued From page 14 and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP floor plans failed to identify the location and number of resident rooms. On October 8, 2024, at 10:45 a.m., survey staff toured the facility with maintenance director (MD)-D. The surveyor observed numbers were posted at all of the resident room doors. Resident room numbers were not included on the evacuation maps displayed in the facility. Resident room numbers are required to be included on the fire safety and evacuation floor plans and used with the numbers installed at the doors to provide efficient communication for exiting in the event of a fire or similar emergency. TRAINING Record review indicated that the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year. No employee FSEP training records were provided. During an interview on October 8, 2024, at 3:15 p.m. LALD-A stated employees completed emergency preparedness training using a third-party online training provider. LALD-A verified FSEP training had not been completed with employees at the frequency required by statute. Record review indicated that the licensee failed to provide fire safety and evacuation training to residents at least once per year. No resident training records were provided for review. During an interview on October 8, 2024, at 3:15 p.m. LALD-A stated residents were trained during admission, and no additional training had been completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by fire drill reports lacking	0 810		

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0 810	Continued From page 15 the required frequency. All of the fire drills were completed during first and second shifts. No drills had been completed during the third shift. In an interview on October 8, 2024, at 3:15 p.m. MD-D verified the evacuation drill frequency was not met. Record review indicated the licensee failed to properly document the building location where the fire drills were performed. The address recorded on six of the eight fire drill reports was 6070 Blanchard Boulevard. The address for the licensed assisted living facility was 6050 Blanchard Boulevard. Two of the eight fire drill reports did not list the address. During an interview on October 8, 2024, at 3:15 p.m. MD-D stated when the fire alarms were activated for a drill, the alarms sounded in both the 6050 and 6070 buildings. MD-D stated the residents of both buildings participated in the same drills. MD-D verified the location for the assisted living building evacuation drills had not been properly documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=E	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		

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01470	Continued From page 16 626.557 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		

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01470	Continued From page 17 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 orientation to assisted living statutes included all the required content for two of three employees, (unlicensed personnel (ULP)-E, registered nurse (RN)-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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 7, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents for employee records. ULP-E ULP-E was hired on June 27, 2023, to provide direct care services to the licensee's residents. On October 8, 2024, the surveyor observed ULP-E administer morning medications to R1. ULP-E's employee record lacked the following required orientation content:	01470		

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01470	Continued From page 18 -overview of 144G assisted living statutes; -compliance with and reporting to the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); and -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 advocacy services. RN-F RN-F was hired on August 13, 2024, to provide direct care services to licensee's residents. RN-F's employee record lacked the following required orientation content: -overview of 144G assisted living statutes; -compliance with and reporting to the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -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 advocacy services; -the assisted living bill of rights and staff responsibility related to ensuring exercising and protection of those rights; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On October 8, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the human resource	01470		

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01470	Continued From page 19 department assigned the Educare (online education training system) courses and CNS-B had reviewed the training to ensure the proper training had been assigned for assisted living regulations. The licensee's HRM-4.0 Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy dated July 2023, indicated newly hired staff will receive orientation and training on topics required for assisted living organizations. At minimum, orientation must include the following topics: -overview of Minnesota Assisted Living law; -the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct support services; -how to report maltreatment of vulnerable adults; and -complaint process-handling resident complaints, the facility's system for receiving and responding to complaints, contact information for the Office if Health Facility Complaints, contact information for the Office of Ombudsman for long-term care and contact information for the office of ombudsman for mental health and disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care,	01540		

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01540	Continued From page 20 direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 observation, interview, and record review, the licensee failed to ensure direct care employees received the required amount of dementia care training in the required time frame for one of three employees unlicensed personnel (ULP-E). 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had a current assisted living facility	01540		

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01540	Continued From page 21 with dementia care license. ULP-E was hired on June 27, 2023, to provide direct care services to the licensee's residents. On October 8, 2024, at 7:35 a.m., the surveyor observed ULP-E administer morning medications to R1. ULP-E's employee record indicated ULP-E had completed six hours of dementia training on June 28, 2023. ULP-E's employee lacked the required eight hours of training on the specific dementia care topics within 80 working hours of ULP-E's hire date. On October 8, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the human resource department assigned the Educare (online education training system) courses and CNS-B had reviewed the training to ensure the proper training had been assigned for assisted living regulations. The licensee's HRM-3.0 Assisted Living with Dementia Care, Dementia Training policy dated July 2023, indicated direct-care employees will complete a minimum of eight hours of initial training on dementia care topics and will be completed within 80 hours of the employment start. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01620	Continued From page 22	01620		
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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for three of three residents (R1, R5, R6) with a change in condition and failed to ensure an ongoing assessment not to exceed 90-calendar days from the last assessment for three of three residents (R1, R2, R6).	01620		

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01620	Continued From page 23 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 October 7, 2024, at 11:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated ongoing assessments are done every 90 days and change of condition assessments would be conducted on residents for instances such as hospital returns, change in services, or a change in condition. CHANGE IN CONDITION/90-DAY ASSESSMENTS R1 R1's diagnoses included diabetes, atrial fibrillation (irregular heartbeat) and congestive heart failure (CHF). R1's service plan dated April 10, 2024, indicated R1 received medication administration, including insulin and obtaining blood sugars, housekeeping and laundry. On October 8, 2024, at 7:35 a.m., the surveyor observed unlicensed peronnel (ULP)-E administer morning medications to R1. R1's progress notes indicated the following: - June 13, 2024, at 7:57 p.m., written by on-call registered nurse (RN), indicated staff called to report resident complaining of teeth and mouth	01620		

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01620	Continued From page 24 pain. Per staff mouth appears swollen. Blood pressure (BP) 149/85, pulse (P) 95, temperature (T) 97.7, oxygen saturation (O2) 93 %. Spouse will bring resident to emergency room (ER) for concern of possible dental infection. She is taking resident to [name] ER. Community nursing to follow-up June 14, 2024. -June 14, 2024, at 8:43 p.m., written by RN, indicated wife took him (R1) to ER last evening due to mouth pain and swelling. Diagnosed with periapical abscess (pocket of pus) and sent back with prescriptions for oxycodone and antibiotic. Both prescriptions faxed to [name] pharmacy this morning. Resident stated he is feeling better than yesterday and was eating fruit. -June 14, at 9:09 p.m., written by RN, indicated staff called to report residents blood sugar is 504 after eating dinner, resident had large portions at dinner. Per staff, resident is alert, no blurred vision, and communicating at baseline. Staff advised to encourage resident to drink plenty of water and go for a walk. Avoid high carbohydrates and sugary snacks. Recheck blood sugar in one to two hours and report to triage. Update: staff called at 10:10 p.m., to report blood sugar is trending down to 219. Staff advised to continue to monitor and report any new symptoms to triage. R1's records indicate 90-day assessments was completed on April 9, 2024, and July 1, 2024. R1's record lacked a change of condition assessment after R1 saw ER with a diagnosis of a dental infection and lacked a 90-day assessment after July 1, 2024. R6 R6's diagnoses include Alzheimer's dementia, chronic renal failure and hypertension (high blood	01620		

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01620	Continued From page 25 pressure). R6's service plan dated December 7, 2023, indicated R6 received medication administration, assist of one with bathing, dressing, toileting, laundry, and housekeeping. R6's incident report (IR)/progress notes (PR)indicated the following: -(IR) May 14, 2024, at 10:50 p.m., written by ULP, indicated R6 was found lying on the floor on her stomach next to her bed, intervention of night light in bedroom and bathroom. Regular rounds. -(PR) May 15, 2024, at 6:22 a.m., written by RN, indicated unwitnessed fall, staff called on-call RN on May 14, 2024, at 10:54 p.m., to report R6 rolled out of bed. R6 was found lying on her back. No apparent head strike, pain or injury per staff. BP 155/92, R 20, P 76, T 97.7. Staff advised to assist R6 off the floor check for pain and injury to report to triage if notes. Vital signs (VS) every shift for 24 hours. Closely monitor resident overnight. Community nursing to follow-up May 15, 2024. Unable to reach spouse. Phone number updated, spoke with daughter [name] was updated on fall. -(PR) May 15, 2024, at 9:02 a.m., written by RN, indicated unwitnessed fall, incident date May 14, 2024, at 10:50 a.m., in bedroom of apartment, R6 said she was going to the mall, resident assistant propping door open and found her laying on her stomach, on the floor next to her bed. -(PR) May 28, 2024, at 11:07 a.m., written by RN, indicated unwitnessed fall in activity area. Another resident was helping R6 from a chair. R6 was sitting on the floor. ULP helped R6 stand and walked to lunch. -(PR) June 3, 2024, 8:28 p.m., written by RN, indicated unwitnessed fall. Staff called on call RN to report resident fell after walking in the hallway.	01620		

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01620	Continued From page 26 Staff believes she was dizzy prior to fall. R6 was found sitting on her bottom. No apparent head strike, pain or injury per staff. BP 112/68, R 17, P 67, T 98.2. Staff advised to assist resident off the floor and check for pain and injury and report to triage if noted. VS every shift for 24 hours. Closely monitor resident overnight. Community nursing to follow up June 4, 2024. Spouse updated regarding fall. -(PR) June 5, 2024, at 2:18 p.m., written by RN, indicated medication change due to increased constipation and bowel movement every 4th day, very large and hard. Nurse practitioner (NP) contacted, new order for senna 8.6 milligrams twice daily. -(PR) June 5, 2024, 3:08 p.m., written by RN, indicated unwitnessed fall in bedroom apartment on June 5, 2024, at 2:40 p.m., BP 169/96, P 73, R 14, Temp 97.4. R6 was getting out of bed on her own and felt wobbly and sat down, resident found sitting on the floor. ULP checked for injuries, put shoes on and helped resident into wheelchair. -(PR) June 11, 2024, 3:41 p.m., written by RN, indicated unwitnessed fall in common area hallway, on July 11, 2024, at 12:55 p.m., BP 148/72, P 78, R 17, Temp 97.2, O2 97%. R6 was walking and tripped on her own shoe. -(PR) June 27, 2024, at 12:30 p.m., written by RN, indicated RN called family regarding hospice. Family agreed to hospice referral. - (PR) June 27, 2024, 12:32 p.m., written by RN, indicated resident refused breakfast this morning, but did eat a cookie. Wheelchair from facility basement brought upstairs for resident to use. She is unable to stand for more than one second. Weight today 103 pounds, she ate 20% of lunch. -(PR) June 27, 2024, at 3:48 p.m., written by RN, indicated R6 saw NP. R6 becoming more frail, functional status also declining, more falls, needing more help with meals. Remains full	01620		

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01620	Continued From page 27 code. Message left for husband to discuss declining status. Medications that could be eliminated include vitamin D, fish oil, multivitamin and calcium. -(PR) July 2, 2024, 8:48 p.m., written by RN, indicated R6 was admitted to hospice. -(PR) July 10, 2024, at 11:08 p.m., written by RN, indicated on call nurse received notification at 6:41 p.m., resident sustained a fall witnessed by other residents only in commons area of dementia care unit. Other residents reported that resident hit the right side of head on the carpeted floor. Resident reported some hip pain. Vitals post fall: BP 91/53, P 86, T 97.1, R 16, O2 96%. Writer (RN) called hospice provider and was informed that hospice nurse would be sent to facility to assess R6. Writer notified resident's spouse who was in agreement with hospice nurse visit. Writer observed update from hospice nurse at 8:34 p.m., that onsite visit completed. Hospice RN reported resident was hypertensive (high blood pressure) but there is a concern that she experiences orthostatic hypotension. Hospice nurse reported that hospice interdisciplinary team (IDT) meeting will take place tomorrow and team will discuss adjusting resident medications. ULP to obtain vitals per facility protocol. Community nursing to follow-up July 11, 2024. Writer requested update from ULP immediately with any concerns regarding resident. -(PR) July 11, 2024, at 9:50 a.m., written by RN, indicated fall follow-up. Resident had a fall yesterday. No apparent injuries from fall. Family and hospice was notified yesterday. Hospice nurse completed visit yesterday evening. Writer completed a fall follow-up today. Resident is alert to self. Resident denied any pain at this time. No bruising observed. Resident participated in morning routine and had breakfast. BP 98/59, P 78.	01620		

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01620	Continued From page 28 -(PR) September 4, 2024, at 5:03 p.m., written by RN, indicated R6 was seen by hospice nurse and Broda chair (tilt-in-space positioning chair) was delivered this afternoon. Chair is in room, will not use until approved by hospice. -(PR) September 10, 2024, at 11:38 p.m., written by RN, indicated staff reported R6 has a sore on her bottom. Writer assessed sore. Noted open sore on right buttock, about the size of a dime, no discharge, no odor, skin is pink and light red around the edges. Hospice will be notified of findings and request barrier cream and supplies. R6's record indicated 90-day assessments was completed on March 15, 2024, and June 26, 2024. R6's record lacked a change of condition assessment after numerous falls, after being placed in a wheelchair June 27, 2024, placed on hospice care July 2, 2024, and placed in a Broda Chair September 4, 2024, and for a wound found on September 10, 2024. Additionally, a 90-day assessment was not completed within 90 days from March 15, 2024 (13 days late) and lacked a current 90-day assessment after June 26, 2024. CHANGE IN CONDITION R5 R5's diagnoses included atrial fibrillation (irregular heartbeat), orthostatic hypotension (form of low blood pressure), and chronic kidney disease. R5's service plan dated August 13, 2024, indicated R1 received medication administration, including the medication Xarelto (a blood thinner), assist of one with bathing, toileting, transfers, ambulation, bed mobility, and housekeeping and laundry.	01620		

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01620	Continued From page 29 R5's incident report (IR)/ progress notes (PR) indicated the following: -(IR) July 5, 2024, at 1:15 a.m., indicated R1 had an unwitnessed fall in the bedroom of her apartment. R5 went to the bathroom alone and fell in the bathroom and crawled back to bedroom to her pendant. R5 was found lying on the floor by her bed with blood on her forehead. Staff called 911 and was transported to the hospital. -(PR) July 5, 2024, at 6:32 a.m., written by RN, indicated R5 had an unwitnessed fall out of bed. At 1:20 a.m., staff called the on-call RN to report R5 used her pendant to alert staff she had fallen on her way to the bathroom. Staff found her tangled in her blankets lying on her right side on the floor next to her bed, R5 hit her head on the carpet. Staff noted bleeding to her right eyebrow and bruising around the eye. Resident complained of pain in her right side near her rib cage per staff. Staff unable to leave resident to get her vital signs cart. Staff advised to call emergency management service (EMS) determined R5 needed to be seen, she was taken to [name] hospital. Daughter [name] updated. Community nursing to follow-up today. -(PR) July 5, 2024, at 11:31 a.m., written by RN, indicated R5 returned from hospital. R5 had a fall after 1:00 a.m., was found on the floor with bleeding right eyebrow. R5 returned to the facility at 9:00 a.m., via ambulance. Laceration to right eyebrow was glued. Blood and urine was cleared for any concerns. She was given breakfast and given her regular morning medications in her room. -(PR) July 7, 2024, at 9:15 a.m., written by RN, indicated staff called this on call nurse to report resident is sore from the fall on July 5, 2024. New bruising noted to right hip about 4 inches in length. R5 advised to continue as needed Tylenol and apply ice for pain relief. Community nursing	01620		

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01620	Continued From page 30 to follow-up July 8, 2024. -(PR) July 9, 2024, at 10:39 a.m., written by RN, indicated R5 was reporting increased pain in right hip area. ULP reports swelling. RN went to assess, round swollen bump noted on outer right thigh beneath hip. Healing bruise noted in the area. Vital signs within normal limits-see health monitoring tab. RN called triage to update [name] NP. -(PR) July 10, 2024, at 9:12 a.m., written by RN, indicated [name] NP ordered x-ray of right hip to rule out fracture. X-ray completed; no acute fracture noted. Results faxed to [name] provider. R5's record indicated a 90-day assessment was completed on July 16, 2024. R5's record lacked a change of condition assessment after R5 saw ER due to an unwitnessed fall with a head laceration and hip bruising and pain. 90-DAY ASSESSMENT R2 R2's diagnoses included Alzheimer's disorder, chronic obstructive pulmonary disorder (COPD) and major depressive disorder. R2's service plan dated June 20, 2024, indicted R2 received medication administration, assist of one for dressing, ambulating, transfers, toileting, bathing, grooming, housekeeping, and laundry. R2's record indicated a 14-day assessment was completed on March 22, 2024, and 90-day assessment was completed June 20, 2024. R2's record lacked a current 90-day assessment after June 20, 2024.	01620		

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01620	Continued From page 31 On October 8, 2024, at 1:18 p.m., CNS-B stated there has been changes in nursing staff and are working on getting 90-day assessments completed. On October 10, 2024, between 1:22 p.m. and 1:50 p.m., during a phone interview with CNS-B, she was asked what constitutes a change of condition? CNS-B stated "A signature change in function that lasts. If a resident goes to the ER and returns and if functioning the same, no change of condition assessment is completed." CNS-B stated during the interview why a change of condition assessment was not completed for the following residents, "[Name] R5 was at baseline when she returned from ER and was functioning the same, so no change of condition assessment needed to be completed. The criteria we use to determine if it is a change in condition is if the decline (or improvement) will not normally resolve itself without staff intervention nor will it resolve itself by implementing standard disease-related clinical interventions. [Name]R1 had an abscess, the abscess is not disease related and wouldn't expect ongoing issues, and the infection is going to resolve with antibiotics, even if he is diabetic. [Name] R6 was globally declining, she had a decline in weight and functions, but wasn't a consistent pattern. We did get physical therapy (PT) involved, she was getting PT and see's house doctors. She does not have a toileting program, but staff would routinely ask her if she needed to use the bathroom. She is on hospice now." The licensee's NUR-5.0 Initial and On-Going Nursing Assessments of Residents policy dated July 2023, indicated the RN will re-assess each resident on an ongoing basis. The RN will determine frequency of re-assessments based on	01620		

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01620	Continued From page 32 the resident needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. The RN will reassess the resident if the resident has a change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=G	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 unlicensed personnel (ULP)-G) in the proper methods to administer medications, and the unlicensed personnel had demonstrated the ability to competently follow the procedures for administering medications. This had the potential to affect all residents receiving assisted living services.	01750		

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01750	Continued From page 33 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 7, 2024, at 10:30 a.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee provided medication management services, and the registered nurses (RN) was responsible for training and completing staff competency evaluations for delegated tasks. ULP-G was hired August 13, 2024, to provide direct care services to the licensee's residents. On October 9, 2024, at 8:00 a.m., the surveyor observed ULP-G administer R11's morning medications without washing hands or using a hand sanitizer before applying and after removal of disposable gloves. On October 9, 2024, at 8:10 a.m., ULP-G stated her training consisted of "Training classes on the computer, then shadowed for a few days, and today is my second day on my own." Surveyor asked if she worked with a nurse, ULP-G stated, "No, I have not worked with a nurse, she just asked how I was doing." On October 9, 2024, at 8:20 a.m., clinical nurse supervisor (CNS)-B stated ULP-G was trained and competencies were completed and would	01750		

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01750	Continued From page 34 reach out to human resources for the documentation. On October 9, 2024, at 10:15 a.m., CNS-B stated ULP-G's training competencies could not be found, and she was sent home with pay until we can get her back in for competency retraining. The licensee's Delegation of Assisted Living Tasks policy dated February 15, 2022, indicated an RN may delegate medication administration to unlicensed personnel only after the RN has verified the unlicensed personnel is educated and trained in the proper methods to administer medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be	01790		

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01790	Continued From page 35 labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and	01790		

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01790	Continued From page 36 (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel ((ULP)-E, ULP-G) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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: ULP-E ULP-E was hired June 27, 2023, to provide direct care services to residents of the assisted living facility which included medication administration. On October 8, 2024, at 7:55 a.m., the surveyor observed ULP-E administer R1's morning scheduled medications. ULP-G ULP-G was hired August 13, 2024, to provide direct care services to residents of the assisted living facility which included medication	01790		

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01790	Continued From page 37 administration. On October 9, 2024, at 7:50 a.m., the surveyor observed ULP-G administer R6's scheduled morning medications. ULP-E and ULP-G's employee records lacked evidence to indicate ULP-E and ULP-G had been trained and demonstrated competency to the registered nurse (RN) to provide medications to residents for unplanned times away from home. On October 11, 2024, at 4:57 p.m., the surveyor received an email from clinical nurse supervisor (CNS)-B in regard to exit conference which read, "Medication management for resident who will be away from home: I have supplied you with the policy, forms and a resource available to our staff to help guide them through this process. I'm assuming this box (on exit conference form) was checked because you had not seen the material prior to exit, and this will now be removed." The email did not include additional evidence to indicate ULP-E or ULP-G had received training and competency testing. The licensee's undated Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away from Home indicated the [facility] will provide the necessary medications, education, instructions and support to meet the residents medication needs when they are away from home if the facility provides assistance with self-administration of medication, administration or storage of medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days	01790		

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01790	Continued From page 38 of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was secured in a locked area for two of seven residents (R7, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 8, 2024, at 1:45 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed and removed the following over the counter (OTC) medications in the bathroom cupboards of	01880		

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01880	Continued From page 39 R7 and R10's apartment style rooms in the dementia care unit: R7 -open bottle of melatonin 5 mg (natural sleep aid); -open bottle of Visine eye drops (dry eyes); -open bottle of antacids; -open bottle of generic tussin cough syrup (cough suppressant); -one opened tube of lidocaine cream (relieves pain); and -one box of fleets enema (relieves constipation). R10 -opened tube of diclofenac sodium cream (reduces pain); and -open bottle of Tums (antacid). On October 8, 2024, at 3:15 p.m., CNS-B stated there should not be any OTC medications in resident rooms and all medications should be locked up. CNS-B stated family must have brought the OTC medications for R7 and R10. Additionally, CNS-B stated R7 recently moved from the adjoining assisted living to the dementia care unit of the facility as family thought she was lonely and needed to be around others. R7's Master Assessment tool dated June 18, 2024, indicated resident requires assistance with medication administration, receives medication administration three times daily, and resident unable to demonstrate secure storage for medications in the apartment. R10's Master Assessment tool dated July 16, 2024, indicated resident requires assistance with medication administration, receives medication administration three times daily, and resident unable to demonstrate secure storage for medications in the apartment.	01880		

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01880	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=D	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to mitigate a safety risk identified in the dementia care assessment of the physical environment. This deficient practice had the ability to affect all dementia care 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 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).	02040		

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02040	Continued From page 41 Findings include: On October 8, 2024, at 10:45 a.m., survey staff toured the facility with maintenance director (MD)-D. The surveyor observed in the dementia care unit that the laundry room door was unlocked and this room was not staffed. During the facility tour interview on October 8, 2024, MD-D verified the laundry room door was not locked. On October 8, 2024, licensed assisted living director (LALD)-A provided a physical environment safety risk assessment for the dementia care unit. This assessment identified the laundry room as a hazard and directed employees to keep the laundry room door locked to mitigate this hazard and protect the dementia care residents from harm. TIME PERIOD FOR CORRECTION: Two (2) days	02040		
02310 SS=F	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, medical, or nursing standards for storage of cleaning supplies.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40167	A. BUILDING: _____ B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

(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 42 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 assisted living with dementia care facility had a capacity of 17 for the secured unit. On October 8, 2024, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated no chemicals should be in any resident rooms in the dementia care unit, all chemicals should be locked up. The surveyor and CNS-B observed and removed the following chemicals in the apartment style rooms in the dementia care unit: -R6, two bottles of Soft Scrub cleaner and one bottle Eco toilet bowl cleaner sitting next to the personal toilet on the floor and isopropyl rubbing alcohol in bathroom cupboard in R6's room; -R8, one bottle of Iron out toilet bowl cleaner sitting next to the personal toilet on the floor in R8's room; -R9, one container of Clorox wipe in kitchen cupboard in R9's room; and -R13, one bottle each of hydrogen peroxide and isopropyl rubbing alcohol in R13's bathroom cupboard. SOFT SCRUB Safety Data Sheet dated September 24, 2018, indicated it was a hazardous chemical, and to avoid contact with eyes, skin or clothing. Use in adequate ventilation and avoid generating	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40167	A. BUILDING: _____ B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

(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 43 aerosols or mists. ECO TOILET BOWL CLEANER Safety Data Sheet dated July 28, 2016, indicated it was a hazardous chemical and to avoid inhalation or contact with eyes, skin, or clothing. IRON OUT TOILET BOWL CLEANER Safety Data Sheet dated March 29, 2018, indicated it was a hazardous chemical and to avoid contact with eyes and skin. CLOROX DISINFECTING WIPES Safety Data Sheet dated April 27, 2015, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. HYDROGEN PEROXIDE Safety Data Sheet dated December 16, 2014, indicated it was a hazardous chemical, and to avoid ingestion or contact with eyes and skin, and avoid contact with heat/sparks/open flames or hot surfaces as may cause fire or explosion. ISOPROPYL RUBBING ALCOHOL Safety Data Sheet dated March 30, 2020, indicated it was a hazardous chemical, and to avoid inhalation, and contact with eyes and skin, and avoid contact with heat/sparks/open flames or hot surfaces as may cause fire or explosion. On October 8, 2024, at 3:15 p.m., CNS-B stated chemicals in the room was an issue and it was probable family brought the chemicals in. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40167	A. BUILDING: _____ B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD LINO LAKES, MN 55014

(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

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/07/24*
Time: 12:30:00
Report: 1025241196

Food and Beverage Establishment Inspection Report

Location:
LYNGBLOMSTEN AT LINO LAKES LLC
6050 BLANCHARD BOULEVARD
Lino Lakes, MN55014
Anoka County, 02

Establishment Info:
ID #: 0043724
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Baked potato
Temperature: 155 Degrees Fahrenheit - Location: Hot holding line
Violation Issued: No

Process/Item: Sliced tomato
Temperature: 40 Degrees Fahrenheit - Location: Prep line grill
Violation Issued: No

Process/Item: Ambient
Temperature: 37 Degrees Fahrenheit - Location: Cafe display
Violation Issued: No

Process/Item: Ground beef
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

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

Facilities:
Main kitchen and Housekeeping unit in service hall
Kitchen attached to Memory Care and Neighborhood Kitchen in Memory Care
Bar/Restaurant and breakfast bar

Café

Cooler temperatures were 41 deg F or below
Hot holding 135 deg F or above

Hotel: If guest rooms are available for stays of less than 7 days, please contact Anoka Co for licensing rooms as a hotel (would be part of the same license as the pool). There is a tangible benefit to the facility, as hotels have the ability to remove overstaying or unwanted guests.

Expansion of facility: If expansion plans were originally submitted for plan review, then the expansion of the kitchen to match those plans is OK. If equipment will be added as part of campus expansion, then submit plans to HRD for a remodel.

Discussed routine testing of equipment (temperatures and sanitizers for dish machines), chemical sanitizers (sink and surface [blue] product vs quat [red]), handwashing sink signage, cooling food (shallow metal pants to cool and transferred to plastic Cambro storage), Time as a Public Health Control, pest control, employee health and hygiene. Pasteurized eggs used. Café food is sold only when attendant is present (in context of food package labeling). Discussed tap line cleaning (most responses I've received from bar operators have been to clean lines everyone 2 weeks to 1 month).

Note: There is a swing door and wall in the dish area. I've seen this set up in older facilities inspected by Compliance and Monitoring (previous agency name). There is no requirement in MN Food Code for dish areas to be separated into sides by a wall or door or other divider. I don't know if this was a formal or informal requirement. I've given the recommendation that the swing door be removed because it impedes access to the sole handwashing sink for the dish area, with the caveat that the door shouldn't be discarded in case there is a formal requirement from another agency for this door (where it should then be reinstalled, as the most restrictive requirements should be followed).

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 1025241196 of 10/07/24.

Certified Food Protection Manager: Jacqueline Leuer

Certification Number: FM86278 Expires: 06/15/25

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241196

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 10/07/24
Time In 12:30:00
Time Out

	Address	City/State	Zip Code	Telephone
LYNGBLOMSTEN AT LINO LAKES LLC	6050 BLANCHARD BOULEVARD	Lino Lakes, MN	55014	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0043724		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature	
19	IN OUT N/A N/O	Proper reheating procedures for hot holding	
20	IN OUT N/A N/O	Proper cooling time & temperature	
21	IN OUT N/A N/O	Proper hot holding temperatures	
22	IN OUT N/A	Proper cold holding temperatures	
23	IN OUT N/A N/O	Proper date marking & disposition	
24	IN OUT N/A N/O	Time as a public health control: procedures & records	
Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food	
Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered	
Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used	
28	IN OUT	Toxic substances properly identified, stored, & used	
Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP	

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/07/24

Inspector (Signature) Gary King