Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 18, 2025

Licensee
Loon Home Health Care LLC
8651 Queen Avenue South
Bloomington, MN 55431

RE: Initial License Number 413118
Health Facility Identification Number (HFID) 40190
Project Number(s) SL40190015

Dear Licensee:

On January 22, 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 September 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 18, 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 18, 2025, MDH is granting your Assisted Living Facility facility license. Your license effective and expiration dates remain the same as on your provisional license. Your license number is 413118. You will not receive a replacement license certificate until your license is due to renew. 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 September 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 September 11, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1890-Prescription Drugs-144g.71 Subd. 20 - $500.00

The details of the violations noted at the time of this follow-up survey completed on January 22, 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, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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).

IMPOSITION OF FINES:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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
	40190	A. BUILDING: _____ B. WING _____	R 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOON HOME HEALTH CARE LLC	8651 QUEEN AVENUE SOUTH BLOOMINGTON, MN 55431

(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 SL40190015-1 On January 21, 2025, through January 22, 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 September 11, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living License. As a result of the follow-up survey, the following order was 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.	

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{0 480}	Continued From page 1	{0 480}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}		

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{0 480}	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 3 (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 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.	

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{01890}	Continued From page 4	{01890}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with open and/or expiration dates for the licensee's one resident with time sensitive medication (R2), and failed to ensure medications were stored with a full pharmacy label for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 2:20 p.m. a review of the medication drawer and medication refrigerator was completed with assisted living director in residency (ALDIR)-A. The following was observed for R2: - three bottles of alphagan eye drops were opened and in use. None of the bottles had a pharmacy label. One bottle was stored in it's box	{01890}		

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{01890}	Continued From page 5 with the full prescription label, one bottle was in a dorzolamide/timolol box labeled with the prescribing information for the dorzolamide/timolol, and one bottle did not have a box with a pharmacy label, thus was not stored with a pharmacy label; - two bottles of dorzolamide/timolol eye drops were opened and in use. One bottle was stored in a box with a pharmacy label; however, there were no instructions for use on the label, and one bottle was in a latanoprost box with the prescribing information for the latanoprost; and - latanoprost was opened and in use and was stored in the medication refrigerator. The latanoprost did not have a pharmacy label and the original manufacturer label on the bottle was worn and unreadable. The latanoprost was not stored in it's box with the original pharmacy label. The latanoprost did not have an opened date written on it. On January 21, 2025, at 2:20 p.m., ALDIR-A stated the eye drops were supposed to be stored in the pharmacy labeled box and should have an open date. ALDIR-A further stated although the medications were in the wrong boxes, the staff would have administered the correct eye drops at the correct times. Latanoprost prescribing information dated August 2011, directed to store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks. The licensee's Storage/Control of Medications policy dated March 18, 2024, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions.	{01890}		

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{01890}	Continued From page 6 The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication 12. The licensed nurse is responsible for dating time-sensitive medications when opened. 13. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use. No further information was provided.	{01890}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

November 4, 2024

Licensee
Loon Home Health Care LLC
8651 Queen Avenue South
Bloomington, MN 55431

RE: Provisional Conditional License Number 413118
Health Facility Identification Number (HFID) 40190
Project Number(s) SL40190015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 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 2, 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 $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $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.

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

CONDITIONAL LICENSE ISSUED

MDH will issue Loon Home Health Care 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 Loon Home Health Care LLC is in substantial compliance.

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

a. **Health Facility Construction Permit:** Loon Home Health Care LLC will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Loon Home Health Care LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Loon Home Health Care LLC must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email within two (2) weeks of the date of this notice:

   i. Name

   ii. License Number

   iii. Contact Information

c. **Egress Window Requirements:** Loon Home Health Care LLC will replace at least one window in occupied sleeping room #1 and occupied sleeping room #2, meeting the minimum size requirements.

   i. Must have minimum openable width of no less than 20 inches.
   ii. Must have minimum openable height of no less than 20 inches.
   iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
   v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

d. **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.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Loon Home Health Care 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 Loon Home Health Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Loon Home Health Care LLC. If MDH determines Loon Home Health Care 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 Jodi Johnson directly at: 507-344-2730.

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
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOON HOME HEALTH CARE LLC	8651 QUEEN AVENUE SOUTH BLOOMINGTON, MN 55431

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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: SL40190015-0 On September 9, 2024, through September 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on September 11, 2024, issued for SL40190015-0, tag identification 0820. On September 12, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOON HOME HEALTH CARE LLC	8651 QUEEN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers and the public as required, and failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors.	0 470		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents, with a current census of five residents. During the entrance conference on September 9, 2024, at 12:00 p.m., assisted living director in residency (ALDIR)-A stated the clinical nurse supervisor (CNS)-B would be responsible for the staffing plan. On September 9, 2024, at 1:10 p.m. the surveyor observed a form titled Staffing Schedule posted in the dining room dated August 11, 2024. ALDIR-A stated it was not current and should have been updated. On September 10, 2024, at 9:41 a.m. CNS-B stated he had created a staffing plan when the licensee had opened and admitted the first resident in October 2023. CNS-B stated although the licensee has added residents and currently the facility was full with five residents, none of the residents required two person assistance so the staffing plan would not have changed. The licensee had no evidence they had developed and implemented a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 3 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. The licensee's Staffing policy dated March 18, 2024, indicated "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs." "1. The staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. 2. The plan considers the number of qualified direct-care staff (home health aides) to meet the residents' needs throughout the day and night. 3. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. Considerations include: · The staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan · The acuity level of the residents based on the nursing assessment · The facility's ability to respond promptly and effectively to residents · Staff experience, training and competence · Dementia care requirements · The physical layout of the residence	0 470		

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0 470	Continued From page 4 4. The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes. 5. Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible. 6. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: · Home health aide work schedules for each home health aide showing all work shifts with days/hours worked · The home health aide's resident assignments or work location 7. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 5 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 6 Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 9, 2024, at 2:44 p.m. the surveyor observed a facility telephone in the dining room area. There was no posting near the phone to call 911 in case of an emergency. On September 9, 2024, at 2:44 p.m. assisted living director in residency (ALDIR)-A stated he was unaware 911 needed to be posted in common areas and by the facility phones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 7 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 680		

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0 680	Continued From page 8 The findings include: The licensee provided a three ring binder labeled Emergency Preparedness Manual dated August 20, 2023. The licensee's undated, emergency preparedness plan lacked evidence of the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - arrangements/contracts to re-establish utility services; - all hazards approach with categorized probable risks/hazards by likelihood of occurrence; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - identification of at-risk population needs like maintaining independence, communication, transportation, supervision and medical care; - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program; - policies and procedures based on the EP, risk assessment and communication plan; - policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe	0 680		

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0 680	Continued From page 9 evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to	0 680		

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0 680	Continued From page 10 provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles. - documentation of all EP training; and - emergency prep testing requirements. On September 11, 2024, at 1:00 p.m. assisted living director in residency (ALDIR)-A stated he was utilizing a emergency preparedness plan provided and had not adjusted it for his facility, and he was unaware it was missing content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 11 by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 11, 2024, from approximately 10:00 a.m. to 12:30 p.m., survey staff toured the facility with the assisted living director in residency (ALDIR)-A. The following was observed. SMOKING AREAS: The residents were using an undesignated smoking area at the rear lower-level stairway. There was no approved ashtrays or receptacles provided. The residents were discarding cigarette butts on the ground and concrete stairway. Survey staff explained to ALDIR-A that an approved ashtray and receptacle shall be provided for resident use and that the discarded cigarette butts were a fire hazard if cigarettes were not completely extinguished before	0 800		

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0 800	Continued From page 12 discarding them. GENERAL MAINTENANCE: It was observed in bedroom 4 multiple items were connected to unapproved extension cords. It was observed throughout the basement, staining caused by a water leak on the ceiling. On the concrete stoop and steps outside the front entrance door, it was observed that the installed floor-mounted guards were loose and were not securely mounted to the floor. On September 11, 2024, at approximately 12:00 p.m., ALDIR-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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	0 810		

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0 810	Continued From page 13 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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 the residents).	0 810		

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0 810	Continued From page 14 The findings include: On September 11, 2024, at approximately 11:00 a.m., ALDIR-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On September 11, 2024, at approximately 11:00 a.m., ALDIR-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING:	0 810		

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0 810	Continued From page 15 Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ALDIR-A was unable to provide documentation showing the required amount of training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. On September 11, 2024, at approximately 11:00 a.m., ALDIR-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident providing documentation of drills completed that were not in the required sequence of every other month and twice per year per shift. On September 11, 2024, at approximately 11:00 a.m., ALDIR-A stated documentation was not available in the required sequence of one fire drill every other month and twice per shift per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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0 820	Continued From page 16 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 11, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with Assisted Living Director In Residency (ALDIR)-A. During the tour, survey staff asked ALDIR-A to open the windows in the resident	0 820	This immediate correction order identified on September 11, 2024, has had the immediacy lifted as of September 12, 2024, however non-compliance remained a scope and level of H.	

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0 820	Continued From page 17 bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 1 on main level: Awning window one measured 31 inches clear width, 10 inches clear height, and 651 square inches total open area for each window. Awning window two measured 31 inches clear width, 21 inches clear height, and 651 square inches total open area for each window. Bedroom 2 on main level: Awning window one measured 31 inches clear width, 10 inches clear height, and 651 square inches total open area for each window. Awning window two measured 31 inches clear width, 21 inches clear height, and 651 square inches total open area for each window. The windows in bedrooms 1, and 2 did not meet the minimum requirements for height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ALDIR-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On September 11, 2024, at 11:30 a.m., survey staff explained to ALDIR-A that an immediate correction order was issued for the above findings. ALDIR-A stated they understood the requirements for egress windows and would	0 820		

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0 820	Continued From page 18 contact the landlord by the end of the day to start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 19 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's unsigned, progress notes indicated on December 18, 2023, at 10:00 a.m. R2 was sent to the hospital. R2 returned on December 19, 2024, at 3:00 p.m. R2's record lacked evidence the facility had provided a written notice that contained, at a minimum: (1) the reason for the relocation;	01060		

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01060	Continued From page 20 (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice was delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; and (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager. On September 10, 2024, at 12:07 p.m. assisted living director in residency (ALDIR)-A stated he was unaware of the requirements for an emergency transfer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 21 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on November 20, 2023.	01380		

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01380	Continued From page 22 ULP-C's record lacked evidence she had been competency tested in the following required areas: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On September 10, 2024, at 8:45 a.m. assisted living director in residency (ALDIR)-A stated ULP-C "worked independently in the home and administers medications." The required competencies were not in ULP-C's file so they "must have been missed." The licensee's Staff Competency policy dated March 18, 2024, indicated training and competency evaluations for all unlicensed personnel would include the following: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motioning and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	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	01470		

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01470	Continued From page 23 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human 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,	01470		

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01470	Continued From page 24 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) received orientation to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on November 20, 2023. ULP-C's record lacked evidence she had received orientation in the following required areas: - Overview of Assisted Living statutes - Review of types of Assisted Living services the employee will provide and provider's scope of license On September 10, 2024, at 8:45 a.m. assisted living director in residency (ALDIR)-A stated ULP-C "works independently in the home and	01470		

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01470	Continued From page 25 administers medications." The required orientation topics "must have been missed." The licensee's Staff Orientation and Education policy dated March 18, 2024, indicated "Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659" "j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=E	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.	01620		

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01620	Continued From page 26 (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 assessment within 14 days of starting services for one of three residents (R2) and and failed to complete a comprehensive assessment every 90 days as required for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2 was admitted to the facility on October 25, 2023. On September 9, 2024, at 3:05 a.m. assisted living director in residency (ALDIR)-A was observed administering medications to R2.	01620		

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01620	Continued From page 27 R2's service plan dated October 25, 2023, indicated R2's services included dressing, grooming, bathing, behavior management, medication management and medication administration. R2's record identified the following assessments: - Uniform Assessment Tool Form completed October 25, 2023 (initial assessment); - [Licensee] Home Health Reassessment form completed November 10, 2023, this was 16 days after admission, thus exceeding 14 calendar days. In addition, the assessment form failed to include all information required in the uniform assessment tool; - Clinical Update Assessment completed on March 17, 2024, which was 128 days after the previous assessment, thus exceeding 90 calendar days. - Clinical Update Assessment completed on June 26, 2024, which was 101 days after the previous assessment, thus exceeding 90 calendar days. R4 R4 was admitted on October 18, 2023. On September 9, 2024, at 3:24 p.m. ALDIR-A was observed administering medications to R4. R4's service plan dated October 18, 2023, indicated R4's services included dressing, grooming, bathing, medication management and medication administration. R4's record identified the following assessments: - Clinical Update Assessment dated March 28, 2024; - Clinical Update Assessment dated June 27, 2024, which was 91 days after the previous assessment, thus exceeding 90 calendar days.	01620		

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01620	Continued From page 28 On September 11, 2024, at 11:18 a.m. ALDIR-A stated assessments should have been completed on admission, at 14 days, and then every 90 days. The licensee's Assessment and Reassessment policy dated March 18, 2024, identified "The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services." "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 29 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three residents (R3) had a service plan signed by the resident or resident's designated representative and the facility to document agreement on the services to be provided. 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: R3 was admitted on June 12, 2024. On September 10, 2024, at 7:30 a.m. assisted living director in residency (ALDIR)-A was observed administering medication to R3. R3's service plan had an effective date of June 29, 2024, and was printed July 13, 2024. The service plan indicated R3's services included medication administration, grooming, housekeeping, and transportation. R3's service plan failed to be authenticated by the resident or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01640	Continued From page 30 their designated representative, and by the facility representative. On September 10, 2024, at 12:35 p.m. ALDIR-A stated the service plan should have been signed by the resident and by himself. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01650	Continued From page 31 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2 was admitted to the facility on October 25, 2023. On September 9, 2024, at 3:05 a.m. assisted living director in residency (ALDIR)-A was observed administering medications to R2. R2's service plan dated October 25, 2023, indicated R2's services included dressing, grooming, bathing, behavior management, medication management and medication administration. R2's service plan failed to include the fees for services as required.	01650		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01650	Continued From page 32 R4 R4 was admitted on October 18, 2023. On September 9, 2024, at 3:24 p.m. ALDIR-A was observed administering medications to R4. R4's service plan dated October 18, 2023, indicated R4's services included dressing, grooming, bathing, medication management and medication administration. R4's service plan failed to include the fees for services as required. On September 10, 2024, at 12:35 p.m. ALDIR-A stated the service plans should have included all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01700	Continued From page 33 address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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) conducted a face-to-face medication management reassessment to include all required content for three of three residents (R2, R3, R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 R2 was admitted to the facility on October 25, 2023. On September 9, 2024, at 3:05 a.m. assisted	01700		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01700	Continued From page 34 living director in residency (ALDIR)-A was observed administering medications to R2. R2's service plan dated October 25, 2023, indicated R2's services included medication management and medication administration. R2's Clinical Update Assessment completed on June 26, 2024, indicated R2 received medication administration. R2's assessment failed to include an identification and review of all medications R2 was known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R3 R3 was admitted on June 12, 2024. On September 10, 2024, at 7:30 a.m. ALDIR-A was observed administering medication to R3. R3's service plan had an effective date of June 29, 2024, and was printed July 13, 2024. The service plan indicated R3's services included medication administration. R3's Clinical Update Assessment completed on June 26, 2024, indicated R3 received medication administration. R3's assessment failed to include an identification and review of all medications R3 was known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R4 R4 was admitted on October 18, 2023. On September 9, 2024, at 3:24 p.m. ALDIR-A	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01700	Continued From page 35 was observed administering medications to R4. R4's service plan dated October 18, 2023, indicated R4's services included medication management and medication administration. R4's Clinical Update Assessment completed on June 27, 2024, indicated R4 received medication administration. R4's assessment failed to include an identification and review of all medications R4 was known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On September 11, 2024, at 11:01 a.m. clinical nurse supervisor (CNS)-B stated the pharmacy reviews the medications. CNS-B stated he discussed medications with the residents and asks if they are having any side effects. However; he did not document that and did not include contraindications. The licensee's undated, Medication Management Program policy indicated the registered nurse was to complete a face to face medication assessment that included a medication reconciliation with the following information: "a. Indication for medications b. Effectiveness of drug therapy c. Side effects d. Immediate desired effects e. Unusual and unexpected effects f. Actual or potential drug interactions g. Duplicate drug therapy h. Non-adherence with drug therapy i. Drug therapy currently associated with laboratory monitoring j. Allergic reactions k. Changes in condition that contraindicate	01700		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01700	Continued From page 36 continued administration of the medication". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as ordered for two of three residents (R2 and R4) and failed to ensure medications were documented as administered or refused for three of three residents (R2, R3, R4) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01760	Continued From page 37 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the facility on October 25, 2023. On September 9, 2024, at 3:05 a.m. assisted living director in residency (ALDIR)-A was observed administering medications to R2. R2's service plan dated October 25, 2023, indicated R2's services included medication management and medication administration. R2's physician orders dated July 3, 2024, included the following orders: - dorzolamide/timolol eye drops apply 1 drop in both eyes twice a day (glaucoma) - tamsulosin 0.4 mg take on capsule daily after a meal (prostate health) - Melatonin 3 mg take one tablet by mouth at bedtime (for sleep) R2's medication administration record (MAR) dated September 1-11, 2024, failed to include: - dorzolamide/timolol eye drops apply 1 drop in both eyes twice a day - tamsulosin 0.4 mg take one capsule daily after a meal - Melatonin 3 mg take one tablet by mouth at bedtime R2's medication dose packs set up by the pharmacy identified the dose packs only contained the following medications:	01760		

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01760	Continued From page 38 - Melatonin 3 mg tablet one tablet by mouth every night The medication dose packs did not include tamsulosin as ordered. R2's medication drawer included dorzolamide/timolol eye drops. Medication reconciliation by the surveyor identified the following discrepancies: - dorzolamide/timolol eye drops was on the physician orders and the facility had the medication; however, it was not listed on the MAR and had not been documented as administered. - tamsulosin was on the physician orders but was not listed on the MAR, and the facility did not have the medication in the dosage packs or in a separate bottle. On September 10, 2024, at 10:34 a.m. clinical nurse supervisor (CNS)-B stated the tamsulosin was on hold because they did not have it and then it was discontinued on August 16, 2024; however, the facility did not have an order to discontinue the medication. Dorzolomide/timolol should be on the MAR and he was unsure why it was not on it. R4 R4 was admitted on October 18, 2023. On September 9, 2024, at 3:24 p.m. ALDIR-A was observed administering medications to R4. R4's Service plan signed October 18, 2023, indicated R4 received medication administration services. R4's physician orders dated April 22, 2024, indicated the following medication orders:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01760	Continued From page 39 - gabapentin 100 mg take one capsule by mouth three times a day (nerve pain, restlessness) - risperidone 1 mg take two tablets by mouth once daily (antipsychotic) - acetaminophen 325 mg as needed [no further directions] (pain reliever) - Trazodone 50 mg take one tablet by mouth every night at bedtime as needed for sleep R4's MAR for September 1-11, 2024, identified the following: - gabapentin 300 mg take two capsules by mouth three times a day - magnesium oxide 400 mg take one tablet by mouth daily - riboflavin 400 mg take one tablet by mouth daily - quetiapine 50 mg take one tablet by mouth at bedtime (administered September 1-5, 2024) - quetiapine 100 mg take one tablet by mouth at bedtime (administered September 6-10, 2024) - risperidone 1 mg take two tablets by mouth daily - acetaminophen as needed (no strength or directions listed) - sumatriptan 50 mg tablet take one tablet by mouth at onset of headache - may repeat in two hours max 4 tablets in 24 hours. R4's medication dose packs set up by the pharmacy identified the dose packs included the following medications: - gabapentin 300 mg cap take one capsule by mouth three times a day - magnesium oxide 400 mg take one tablet by mouth daily - riboflavin 400 mg take one tablet by mouth daily - quetiapine 50 mg take one tablet by mouth every night at bedtime In addition, R4's medication drawer included a prescription bottle for quetiapine 100 mg tablet take one tablet by mouth at bedtime.	01760		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01760	Continued From page 40 Medication reconciliation by the surveyor identified the following discrepancies: - gabapentin: R4's order indicated 100 mg take one capsule by mouth three times a day; however, R4's dose pack identified gabapentin 300 mg take one capsule by mouth three times a day was set up by the pharmacy, and R4's MAR staff were documenting administration of gabapentin 300 mg take two capsules (600 mg) three times per day. - risperidone: R4's order and MAR indicated risperidone 1 mg take two tablets by mouth once daily and was being signed as administered; however, the dose pack from the pharmacy did not contain risperidone - magnesium oxide - was included on the MAR and included in the dose packs; however, the facility did not have an order for the medication - riboflavin: was included on the MAR and included in the dose packs; however, the facility did not have an order for the medication - quetiapine: the MAR indicated 50 mg was administered on September 1-5, and 100 mg was administered September 6-10; however, the pharmacy had 50 mg tablets in the dose packs and a bottle of 100 mg tablets. The facility lacked an order for quetiapine. - acetaminophen: contained no directions for use in the order or on the MAR - Trazodone: the facility had an order for the medication but it was not on the MAR - sumatriptan was on the MAR; however, the facility did not have a physician order for the medication. On September 11, 2024, at 11:01 a.m. CNS-B stated the pharmacy had access to the electronic medical record (EMR) used by the facility. The pharmacy received the order and would enter it	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01760	Continued From page 41 into the EMR and send the medications. CNS-B stated he would then check the medication label to the EMR, not the physician order. The pharmacy should be sending a copy of the order to the facility. Medication Documentation R2 R2's September 1-10, 2024, MAR identified the following missed documentation: - latanaprost: bedtime dose on September 4, 6, 8, 2024. R3 R3's September 1-10, 2024, MAR identified the following missed documentation: - multivitamin: a.m. dose on September 4 and 6, 2024. - mirtazapine: 9:00 p.m. dose on September 5, 2024. R4 R4's September 1-10, 2024, MAR identified the following missed documentation for gabapentin: - September 4, 2024, - a.m., p.m., and bedtime dose - September 5, 2024, bedtime dose - September 6, 2024, p.m. and bedtime dose - September 8, 2024, p.m. and bedtime dose - September 10, 2024, bedtime dose. The licensee's Medication Orders policy dated March 18, 2024, identified "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident." The licensee's Medication Documentation policy	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01760	Continued From page 42 dated March 18, 2024, identified "Each medication administered by [licensee] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain signed physician orders for medications administered for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on October 18, 2023.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01820	Continued From page 43 On September 9, 2024, at 3:24 p.m. assisted living director in residency (ALDIR)-A was observed administering medications to R4. R4's Service plan signed October 18, 2023, indicated R4 received medication administration services. R4's physician orders dated April 22, 2024, indicated the following medication orders: - gabapentin 100 mg take one capsule by mouth three times a day (pain or restless legs) - risperidone 1 mg take two tablets by mouth once daily (antipsychotic) - acetaminophen 325 mg as needed [no further directions] (pain reliever) - Trazodone 50 mg take one tablet by mouth every night at bedtime as needed for sleep R4's medication administration record (MAR) for September 1-11, 2024, identified the following: - magnesium oxide 400 mg take one tablet by mouth daily - riboflavin 400 mg take one tablet by mouth daily - quetiapine 50 mg take one tablet by mouth at bedtime, administered September 1-5, 2024 - quetiapine 100 mg take one tablet by mouth at bedtime, administered September 6-10, 2024 - sumatriptan 50 mg tablet take one tablet by mouth at onset of headache - may repeat in two hours max 4 tablets in 24 hours. R4's medication dose packs set up by the pharmacy identified the dose packs included the following medications: - magnesium oxide 400 mg take one tablet by mouth daily - riboflavin 400 mg take one tablet by mouth daily - quetiapine 50 mg take one tablet by mouth	01820		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01820	Continued From page 44 every night at bedtime In addition, R4's medication drawer included a prescription bottle for quetiapine 100 mg tablet take one tablet by mouth at bedtime. Medication reconciliation by the surveyor identified the following discrepancies: - magnesium oxide - was included on the MAR and included in the dose packs; however, the facility did not have an order for the medication; - riboflavin - was included on the MAR and included in the dose packs; however, the facility did not have an order for the medication; - quetiapine - the MAR indicated 50 mg was administered on September 1-5, and 100 mg was administered September 6-10; however, the pharmacy had 50 mg tablets in the dose packs and a bottle of 100 mg tablets. The facility lacked an order for quetiapine; - sumatriptan was on the MAR; however, the facility did not have a physician order for the medication. On September 11, 2024, at 11:01 a.m. clinical nurse supervisor (CNS)-B stated the pharmacy had access to the electronic medical record (EMR) used by the facility. The pharmacy received the order and would enter it into the EMR and send the medications. CNS-B stated he would then check the medication label against the EMR, not the physician order. CNS-B further stated the pharmacy should be sending a copy of the order to the facility. The licensee's Medication Order policy dated March 18, 2024, identified "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident."	01820		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01820	Continued From page 45 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored at the correct temperature per the medication manufacturer recommendations for the licensee's one resident with refrigerated medications (R2), failed to ensure time sensitive medications were labeled with open and/or expire dates for the licensee's one resident with time sensitive medication (R1), and failed to ensure over the counter medications were labeled with the resident's name for the licensee's two residents with over the counter medications (R3 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01890		

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01890	Continued From page 46 The findings include: On September 9, 2024, at 3:09 p.m. surveyor observed a locked medication refrigerator in the office area. The refrigerator did not have a thermometer. The refrigerator contained latanoprost eye drops open and in use for R2 and were not labeled with an open or expire date. Assisted living director in residency (ALDIR)-A stated there should have been a thermometer in the refrigerator and he removed one from the kitchen freezer and placed it in the medication refrigerator. At 3:55 p.m., it was noted the refrigerator temperature was 30 degrees Fahrenheit. ALDIR-A stated he was unsure what the temperature should be and was unaware the latanoprost was a time sensitive drug and should be labeled with an open and expire date. On September 10, 2024, at 6:45 a.m. the surveyor observed the temperature of the medication refrigerator to be 30 degrees Fahrenheit. ALDIR-A stated he must have adjusted the temperature the wrong way and again adjusted the temperature. The licensee's Temp - Meds Refrigerator log identified temps once daily September 1-9, 2024, with all results being 33 degrees Fahrenheit. Latanaprost prescribing information dated August 2011, indicated "Store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." On September 9, 2024, at 3:17 p.m. a review of the medication cabinet was completed with ALDIR-A with the following noted:	01890		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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01890	Continued From page 47 - R3 had Centrum Men's multivitamin and Vitamin D3 over the counter bottles that were not labeled with R3's name or other identifying information. - R5 had aspirin that was not labeled with R5's name or other identifying information. On September 10, 2024, at 9:13 a.m. clinical nurse supervisor (CNS)-B stated medications should be stored per manufacturer directions. The licensee's Storage/Control of Medications policy dated March 18, 2024, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. " The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication 12. The licensed nurse is responsible for dating time-sensitive medications when opened. 13. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use." "17.Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information was provided.	01890		

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01890	Continued From page 48 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or	02240		

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	40190	A. BUILDING: _____ B. WING _____	09/11/2024

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02240	Continued From page 49 title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide all five residents with the Minnesota Bill of Rights for Assisted Living. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 9, 2024, at approximately 12:30 p.m., the surveyor requested admission information given to residents including the Bill of Rights. The licensee provided the Minnesota Home Care Bill of Rights, instead of the assisted living version. On September 9, 2024, at 2:12 p.m. assisted living director in residency (ALDIR)-A stated all the residents would have received the Minnesota	02240		

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02240	Continued From page 50 Home Care Bill of Rights. ALDIR-A stated he was unaware there was an assisted living version of the bill of rights, and he believed he had been using the correct version. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

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

Type: Full
Date: *09/10/24*
Time: 09:34:47
Report: 8044241276

Food and Beverage Establishment Inspection Report

Location:
Loon Home Health Care LLC
8651 Queen Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0043382
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 6127151920
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

Breakfast potatoes measured at 81 degrees F.

Potatoes reheated to 165 degrees F while on site.

Comply By: 09/10/24

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

Household cleaner used on food-contact surfaces as a sanitizer.

Comply By: 09/10/24

4-500 Equipment Maintenance and Operation

4-502.12 ***** Priority 1 *****

MN Rule 4626.0825 Provide single-use kitchenware and single-service and single-use articles where cleaning and sanitizing facilities are not provided.

No sanitizer on site. Chlorine bleach will be purchased before lunch is prepared.

Comply Before Opening

4-700 Sanitizing Equipment and Utensils

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

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

Utensils not sanitized after cleaning.

All dishes must be sent through dishwasher.
Comply By: 09/10/24

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

No stem thermometer.
Comply By: 09/11/24

4-300 Equipment Numbers and Capacities

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

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

No stickers or thermometer for dishwasher.
Comply By: 09/16/24

4-200 Equipment Design and Construction

4-201.11AMN

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

Cooked broccoli cooled in domestic refrigerator.
Comply By: 09/10/24

Surface and Equipment Sanitizers

Hot Water: = at 160.0 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Milk in fridge
Violation Issued: No

Type: Full
Date: *09/10/24*
Time: 09:34:47
Report: 8044241276
Loon Home Health Care LLC

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40.0 Degrees Fahrenheit - Location: Cooked broccoli in fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Process/Item: Hot Holding
Temperature: 81 Degrees Fahrenheit - Location: Breakfast potatoes
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	2	1

HRD inspection conducted with Nurse Evaluator Stacy Haag. Inspection report reviewed on site with

Domestic kitchen consists of vinyl floors, wooden hollow-base cabinets, painted gypsum walls & ceilings, and domestic equipment, including a dishwasher.

Establishment Info: loonhomehealthcare@gmail.com

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 8044241276 of 09/10/24.

Certified Food Protection Manager: Lencho H. Hassen

Certification Number: FM121907 Expires: 03/08/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Lencho

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us