*Protecting, Maintaining and Improving the Health of All Minnesotans*

# NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

February 3, 2025

Licensee
Alnas Lodge LLC
2521 Edinbrook Terrace North
Brooklyn Park, MN  55443

RE: Denial of License Number 413750
Health Facility Identification Number (HFID) 40267
Initial survey; Project Number(s) SL40267015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on December 19, 2024, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

**REQUEST FOR RECONSIDERATION PROCESS**
In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **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**

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

**REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS**
You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than February 6, 2025**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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.

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

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 |
|---|---|---|---|
| | 40267 | A. BUILDING: _____ B. WING _____ | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ALNAS LODGE LLC | 2521 EDINBROOK TERRACE NORTH BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL40267015-0<br><br>On December 16, 2024, through December 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was 1 resident; 1 resident receiving services under the Provisional Assisted Living Facility license.<br><br>An immediate order for correction was identified on December 16, 2024, issued for SL40267015-0, tag identification 0470.<br><br>During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.<br><br>An immediate order for correction was identified on December 18, 2024, issued for SL40267015-0, tag identification 1750.<br><br>During the survey, the licensee took action to | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 000 | Continued From page 1<br><br>mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. | 0 000 | | |
| 0 330 SS=F | 144G.30 Subd. 4 Information provided by facility<br><br>(a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.<br>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey.<br><br>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).<br><br>The findings include:<br><br>The licensee held a Provisional Assisted Living Facility license effective September 29, 2023, with an expiration date of September 28, 2024. | 0 330 | | |

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| 0 330 | Continued From page 2<br><br>On December 16, 2024, at 9:38 a.m., during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they were normally present at the facility from 8:00 a.m., until 5:00 p.m.<br><br>Unlicensed personnel (ULP)-G was hired November 28, 2024, to provide direct care services.<br><br>On December 18, 2024, at 2:24 p.m., ULP-G stated they provided direct cares to residents including medication administration. ULP-G stated CNS/LALD-D typically left the facility around 5:00 p.m., but sometimes left earlier. ULP-G stated they had administered medications to R1 without CNS/LALD-D or another registered nurse (RN) in their presence.<br><br>R1's medication administration record dated December 1, 2024, through December 31, 2024, indicated ULP-G administered oral medications to R1 at 8:00 p.m., on December 11, 2024, December 12, 2024, and December 13, 2024. The record lacked any indication ULP-G was supervised or assisted during the medication administration.<br><br>On December 18, 2024, at 2:47 p.m., the Department issued an immediate order (I/O) to the licensee at order number 1750, related to unlicensed personnel passing medications without having demonstrated competency to a RN. The information presented in the immediate order included the following:<br>-CNS/LALD-D's hours of work were typically 8:00 a.m., to 5:00 p.m.,<br>-ULP-G passed medications at 8:00 p.m.,<br>-ULP-G stated they passed medications | 0 330 | | |

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| 0 330 | Continued From page 3<br><br>independently, without supervision of CNS/LALD-D or another RN,<br>-ULP-G's employee record had no evidence of medication administration competency, and<br>-CNS/LALD-D stated ULP-G was "90 percent competent" to administer medications and there was no way to demonstrate to the surveyor they (CNS/LALD-D) were present for all medication passes signed for by ULP-B or ULP-G.<br><br>On December 19, 2024, at 9:06 a.m., CNS/LALD-D responded to the I/O in an email to the survey supervisor. CNS/LALD-D indicated their plan of correction included to educate employees and to provide ongoing reeducation on medication administration steps and procedures for safe medication administration. The plan of correction indicated the education would occur that day (December 19, 2024). The plan of correction further indicated the licensee would implement an electronic medical record. The plan did not address ensuring an RN was present in the facility to administer medications, or supervise ULPs during the 8:00 p.m., medication administration time.<br><br>On December 19, 2024, at 12:15 p.m., via email, the survey supervisor requested further elaboration, specifically, the licensee's plan to address the following immediate concerns:<br>-the licensee's the plan to protect the safety of the residents related to ULPs administering medications independently who had not demonstrated competency,<br>-how was CNS/LALD-D going to re-train those staff to ensure they could demonstrate competency, and<br>-was CNS/LALD-D going to be present for each shift that the staff worked and watch each medication pass until they were competent. | 0 330 | | |

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| 0 330 | Continued From page 4<br><br>On December 19, 2024, at 1:17 p.m., CNS/LALD-D responded via email to the supervisor's request to address ULPs passing medications without supervision. CNS/LALD-D stated, "The hour (sic) surveyor noted above [8:00 a.m. to 5:00 p.m.] was the old LALD hour (sic) in November 2023, when I had my first client, who was discharged about two months later. With the current client that needs more care and staff to be on duty, I ' m in the facility every day for 12 to 16 hours. It varies based on the staffing level." This statement contradicted earlier statements made by both ULP-G and CNS/LALD-D, indicating the current working hours for CNS/LALD-D were 8:00 a.m. to 5:00 p.m.<br><br>Although CNS/LALD-D stated during the entrance conference their typical working hours were 8:00 a.m. to 5:00 p.m., which was corroborated during an interview with ULP-G, when the licensee received their immediate correction order, CNS/LALD-D then alleged they had been working 12-16 hour shifts since R1 was admitted.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 330 | | |
| 0 470 SS=G | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet | 0 470 | | |

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| 0 470 | Continued From page 5<br><br>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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure that two or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs for one of one resident (R1) who required the assistance of two staff.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a | 0 470 | During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. | |

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| 0 470 | Continued From page 6<br><br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>The licensee's undated Facility Staffing Plan indicated one direct care staff was scheduled to work at the facility each shift from Monday through Sunday and there were three shifts.<br><br>The licensee's staffing schedule dated December 15, 2024, through December 28, 2024, indicated the following shift patterns: Sunday December 15, 2024, Monday December 16, 2024, Tuesday December 17, 2024, Saturday December 21, 2024, and Sunday December 22, 2024, there were three shifts: 7:00 a.m. until 3:00 p.m., 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00 a.m. For Wednesday December 18, 2024, Thursday December 19, 2024, and Friday December 20, 2024, there were two shifts: 7:00 a.m., until 7:00 p.m., and 7:00 p.m., until 7:00 a.m.<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease (damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood | 0 470 | | |

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| 0 470 | Continued From page 7<br>sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility with the Hoyer lift (patient lift device), meal preparation, medication administration, vital signs, clean bathroom, linen exchange, laundry, and room cleaning.<br><br>R1's Home Health Aide Care Plan indicated R1 needed assistance with mobility and transfer. R1's transfer type indicated "Hyer (sic) lift only with assist of two".<br><br>On December 16, 2024, at 10:33 a.m., on the main-level area of the three-level home, the surveyor observed R1's bedroom. The surveyor observed R1 in a hospital style bed with bilateral bedrails. In the room was a Hoyer lift. On the Hoyer lift were the following identifying markings, "Medline, Ref MDS88200D, Lot 83224010001." On top of the Hoyer lift was a blue sling (a mat that goes underneath a person, where the Hoyer lift attaches to). The surveyor did not observe a wheelchair or electric wheelchair anywhere else in the facility. R1 stated their electric wheelchair was located at their previous home. R1 stated the previous home would not release their personal effects to them, and the Community Access for Disability Inclusion (CADI) case manager ((CM)-E) was working on moving the personal effects to [licensee].<br><br>On December 16, 2024, at 11:52 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated R1 discharged from a hospital to the licensee without their personal effects including their electric wheelchair. | 0 470 | | |

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| 0 470 | Continued From page 8<br><br>CNS/LALD-D stated they were working with CM-E to obtain the personnel effects from R1's previous home. CNS/LALD-D stated R1 refused to use a manual wheelchair that was offered to them.<br><br>On December 16, 2024, at 12:09 p.m., unlicensed personnel (ULP)-B stated they were hired to provide direct care services to residents. ULP-B stated they had not moved R1 from their hospital bed to a wheelchair since the resident was admitted. ULP-B stated in an emergency they would transfer R1 to a wheelchair to move R1 out of the facility. The surveyor inquired to ULP-B where the wheelchair was stored. ULP-B showed the surveyor a cardboard box in the laundry room located at the front of the assisted living facility (ALF). ULP-B stated they would contact the CNS, call emergency services, unpack the wheelchair, and take the wheelchair into R1's room. ULP-B stated they were trained to wait for a second staff member to arrive before using the Hoyer lift to move R1 from their bed to the wheelchair. R1 stated CNS/LALD-D was within five minutes of travel distance to the facility. ULP-B stated R1 required two staff members to transfer.<br><br>On December 16, 2024, at 12:56 p.m., CNS/LALD-D stated R1 was a two-person transfer (resident was assessed that two staff members were required to transfer R1 safely). CNS/LALD-D stated they were at the facility seven days per week, normally arriving at 8:00 a.m., and they would leave around 5:00 p.m. CNS/LALD-D stated they trained staff to call CNS/LALD-D if R1 required a transfer from the hospital bed to a wheelchair when the second staff member was not present. CNS/LALD-D stated they lived a two-minute walk from their | 0 470 | | |

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| 0 470 | Continued From page 9<br><br>home residence to the ALF. CNS/LALD-D stated the staffing plan should have reflected two staff members were required to transfer R1 and it was an oversight for not scheduling the correct number of staff.<br><br>The licensee's Staffing policy dated April 10, 2023, indicated licensee would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meeting residents needs at all times.<br><br>Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subpart 5., indicates, "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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 | 0 480 | | |

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| 0 480 | Continued From page 10<br>CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(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;<br>(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;<br>(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;<br>(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;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. | 0 480 | | |

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| | 40267 | A. BUILDING: _____ B. WING _____ | 12/19/2024 |

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| 0 480 | Continued From page 11<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the | 0 510 | | |

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| 0 510 | Continued From page 12<br><br>national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, and medical and nursing standards for infection control for two of two staff (clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D, unlicensed personnel (ULP)-B).<br><br>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).<br><br>The findings include:<br><br>On December 17, 2024, at 11:12 a.m., the surveyor observed CNS/LALD-D and ULP-B enter R1's room located on the main level. Without performing hand hygiene, CNS/LALD-D and ULP-B both donned clean gloves. ULP-B walked to the left side of the hospital bed and CNS/LALD-D walked to the right side of the bed. ULP-B pulled down R1's bedcovers. CNS/LALD-D unhooked a urine catheter night bag (a urine collection bag that is connected to a | 0 510 | | |

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| 0 510 | Continued From page 13<br><br>Foley catheter-a device used to drain urine from the bladder) that was hanging along the edge of the bed and laid it onto R1's bed. ULP-B unfastened R1's adult brief and observed stool. CNS/LALD-D assisted R1 to roll on their left side, facing ULP-B, and folded in the adult brief, covering the stool. CNS/LALD-D wiped R1's buttock and thigh area to clean the skin. CNS/LALD-D rolled up the drawsheet (a bedsheet that is underneath the resident to aid with positioning), and absorbent pad lengthways toward R1. Without removing their gloves, ULP-B exited R1's room. Approximately one minute later, ULP-B returned to R1's room with a blue absorbent pad and a bottle containing nystatin powder (a prescribed medication that prevents fungal growth). Without removing gloves and performing hand hygiene CNS/LALD-D retrieved a clean adult brief from R1's closet. CNS/LALD-D removed the soiled adult brief and placed it into the trash can. CNS/LALD-D unfolded the new adult brief and placed it under R1. CNS/LALD-D wiped R1's right thigh again, assisted R1 to roll onto their back, and removed gloves. Without performing hand hygiene, CNS/LALD-D donned a clean pair of gloves, applied nystatin powder to R1's groin area and fastened the clean adult brief. CNS/LALD-D placed the soiled brief into the trash can. Without changing gloves or performing hand hygiene after the incontinence care, ULP-B picked up the urine catheter night bag and returned it to hang on the edge of the bed.<br>-at 11:23 a.m., CNS/LALD-D removed gloves and exited R1's room without performing hand hygiene.<br>-at 11:25 a.m., without changing gloves, ULP-B carried the trash can from R1's room to the laundry room, transferred the adult brief into another larger trash can, then removed gloves and performed hand hygiene at the sink in the | 0 510 | | |

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| 0 510 | Continued From page 14<br>laundry room.<br><br>On December 17, 2024, at 11:39 a.m., ULP-B stated they were trained to perform hand hygiene before donning gloves and after glove removal, and to change gloves and perform hand hygiene after touching a resident. ULP-B stated they forgot to remove their gloves and perform hand hygiene while assisting R1.<br><br>On December 17, 2024, at 11:52 a.m., CNS/LALD-D stated they trained staff to perform hand hygiene before donning and after glove removal, and to change gloves and perform hand hygiene after performing cares. CNS/LALD-D stated that situation should not have occurred, and was probably situational, as the surveyor was in the room.<br><br>The licensee's Infection Control policy dated April 10, 2023, indicated licensee would observe recommendations from the Center for Disease Control (CDC).<br><br>The CDC Hand Hygiene for Healthcare workers dated February 27, 2024, recommends changing gloves and performing hand hygiene.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 620 SS=D | 144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma<br><br>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section | 0 620 | | |

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| 0 620 | Continued From page 15<br>626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.<br><br>The requirement in Minnesota Statute section 626.557, Subd. 3 is:<br>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:<br>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or<br>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).<br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.<br>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.<br>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause | 0 620 | | |

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| 0 620 | Continued From page 16<br><br>(5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment , by not reporting to the Minnesota Adult Abuse Reporting Center (MAARC), for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services. | 0 620 | | |

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| 0 620 | Continued From page 17<br><br>R1's diagnoses included bilateral (both) below the knee amputation, atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease (damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received services including assistance with dressing, grooming, toileting, mobility with the Hoyer lift (patient lift device), meal preparation, medication administration, vital signs, laundry, and housekeeping.<br><br>R1's Vulnerability Assessment dated November 25, 2024, indicated R1 was not at risk to be abused by others and was not at risk to abuse others.<br><br>On December 16, 2024, at 10:30 a.m., and 10:33 a.m., during a facility tour the surveyor observed R1 lying on a hospital bed. In the room was a Hoyer lift (a device that is used to transfer a resident from one position to another). The surveyor did not observe an electric wheelchair anywhere else in the facility. R1 stated their electric wheelchair was located at their previous assisted living facility (ALF). R1 stated the previous ALF would not release their personal effects to the licensee and the Community Access for Disability Inclusion (CADI) case manager (CM)-E was working on moving the | 0 620 | | |

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| 0 620 | Continued From page 18<br>personal effects to [licensee].<br><br>On December 16, 2024, at 11:52 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated R1 discharged from hospital to the licensee without their personal effects, including their electric wheelchair. CNS/LALD-D stated they were working with CM-E to obtain the personal effects from R1's previous ALF. CNS/LALD-D stated R1 refused to use a manual wheelchair that was offered to them. CNS/LALD-D stated they sent a staff member to R1's previous ALF to collect R1's personal effects. When the staff member arrived to the previous ALF, police were called and the staff member was not able to retrieve R1's personal effects.<br><br>On December 17, 2024, at 12:58 p.m., CNS/LALD-D stated they were mandated reporters and if they suspect abuse or neglect they were required to a file a MAARC report right away. CNS/LALD-D stated they believed CM-E had filed the MAARC report but did not receive confirmation the report had been filed. CNS/LALD-D stated they also believed a MAARC report was not warranted because the licensee had provided clothing and offered the use of a manual wheelchair. CNS/LALD-D believed the immediate need of R1 was clothing not the electric wheelchair.<br><br>On December 18, 2024, at 11:41 a.m., via the telephone, CM-E stated R1's personal effects including the electric wheelchair were still located at the previous ALF. CM-E stated they were informed by the previous ALF they would not release R1's personal belongings to the admitting licensee because there was no prior authorization from R1. CM-E stated they did not file a MAARC | 0 620 | | |

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| 0 620 | Continued From page 19<br><br>report and were instructed by their leadership to file a police report pertaining to the situation.<br><br>The licensee's Vulnerable Adult policy dated April 10, 2023, defined a vulnerable adult as, "Anyone 18 years of age or older, who regardless of where the person is living, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function, or emotional status." The policy indicated when abuse or neglect is suspected, the report was required to be completed with 24 hours.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 620 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>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:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(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<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post the 911 emergency number in | 0 640 | | |

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| 0 640 | Continued From page 20<br><br>common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On December 17, 2024, at 12:54 p.m., during a facility tour, the surveyor observed there was no 911 emergency number posted near the landline telephone located in the kitchen. Unlicensed personnel (ULP)-B stated the residents used the phone to make and receive telephone calls. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated residents used the telephone if they did not have a cell phone. CNS/LALD-D stated they were unaware of the requirement to post the 911 emergency number near the telephones provided by the licensee.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each | 0 650 | | |

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| 0 650 | Continued From page 21<br><br>individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-B, ULP-G, and ULP-H).<br><br>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). | 0 650 | | |

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| 0 650 | Continued From page 22<br>The findings include:<br><br>ULP-B was hired November 27, 2024, to provide direct care services.<br><br>On December 18, 2024, at 8:40 a.m., ULP-B was observed performing personal cares for R1.<br><br>ULP-G was hired November 28, 2024, to provide direct care services.<br><br>ULP-H was hired November 6, 2023, to provide direct care services.<br><br>ULP-B, ULP-G, and ULP-H's employee files each lacked a job description.<br><br>On December 19, 2024, at 9:46 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they were aware a copy of the job description was to be included in the employee file. CNS/LALD-D stated they believed the job descriptions were located in the employee files already.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis | 0 660 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 0 660 | Continued From page 23<br><br>Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening within 90 days of hire for three of three employees (unlicensed personnel (ULP)-B, ULP-G, and ULP-H)<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>ULP-B was hired November 27, 2024, to provide direct care services.<br><br>On December 18, 2024, at 8:40 a.m., ULP-B was | 0 660 | | |

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| 0 660 | Continued From page 24<br>observed performing personal cares for R1.<br><br>ULP-B's employee file included a chest x-ray dated October 31, 2024. The record indicated the reason for the chest x-ray was, "positive TB", and the impression/result was a negative chest x-ray. ULP-B's employee record lacked a documented positive TB test and lacked a TB history and symptom screening tool completed upon hire.<br><br>ULP-G<br>ULP-G was hired November 28, 2024, to provide direct care services.<br><br>On December 18, 2024, at 2:19 a.m., the surveyor observed ULP-G in the kitchen, unpacking groceries.<br><br>ULP-G's employee file included a chest x-ray dated October 31, 2024. The file indicated the reason for the chest x-ray was, "positive TB", and the impression/result was a negative chest x-ray. ULP-B's employee record lacked a documented positive TB test and lacked a TB history and symptom screening tool completed upon hire<br><br>ULP-H<br>ULP-H was hired November 6, 2023, to provide direct care services.<br><br>ULP-H's employee file included a QuantiFERON(R)-TB Gold Plus TB blood test dated October 11, 2023, with a final result of negative. ULP-F's employee record lacked a TB history and symptom screening tool completed upon hire.<br><br>On December 19, 2024, at 9:51 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they completed the TB | 0 660 | | |

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| 0 660 | Continued From page 25<br><br>history and symptom screening form with each employee. CNS/LALD-D stated each employee took the original TB screening form with them for the TB testing. CNS/LALD-D stated they did not keep a copy of the TB history and symptom screening form, and were not aware they were required to keep a copy in the employee record.<br><br>The licensee's Tuberculosis Screening/Prevention policy dated April 10, 2023, indicated the licensee would observe the required screening related to TB from the CDC and the Minnesota Department of Health (MDH).<br><br>The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers, which consisted of assessment for current symptoms of active TB disease, assessing TB history, testing for the presence of infection Mycobacterium tuberculosis by administered either a two-step tuberculosis skin test (TST), or single interferon gamma release assay (a blood test to determine if a person has been infected with TB).<br><br>The CDC's Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB disease.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |

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| 0 680 | Continued From page 26 | 0 680 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>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 the Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. | 0 680 | | |

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| 0 680 | Continued From page 27<br><br>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).<br><br>The findings include:<br><br>The licensee's emergency disaster preparedness plan dated July 2021, lacked evidence of the following required content:<br>- annual review;<br>- hazardous vulnerability risk assessment;<br>- emerging infectious diseases;<br>- procedures for tracking of staff and patients;<br>- policies and procedures including evacuation;<br>- policies and procedures for medical documents;<br>- policies and procedures for volunteers;<br>- arrangement with other facilities;<br>- names/contact information for staff, entities providing services under agreement, residents physicians, other facilities, and volunteers;<br>- emergency official contact information;<br>- primary and alternative means for communication;<br>- methods for sharing information;<br>- sharing information on occupancy and needs;<br>- long-term care (LTC) family notifications; and<br>- emergency preparation and testing requirements.<br><br>On December 18, 2024, at 9:58 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they were responsible for creating the EPP, and they enlisted the help of a consultant company to assist with creating plan. | 0 680 | | |

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| 0 680 | Continued From page 28<br><br>CNS/LALD-D stated they believed the EPP contained all the required information but was unsure what all the required content included.<br><br>The licensee's Emergency Preparedness policy dated April 10, 2023 indicated, "[licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; | 0 780 | | |

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| 0 780 | Continued From page 29<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide carbon monoxide (CO) detectors in required locations and failed to comply with the provisions of Minnesota State Fire Code under MN Rules chapter 7511. These deficient conditions had the ability to affect all staff and residents.<br><br>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).<br><br>The findings include:<br><br>On December 17, 2024, at approximately 10:30 a.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D. During the tour it was observed the carbon monoxide (CO) detector was not installed on the main level. The surveyor explained to CNS/LALD-D the potential life safety hazard not having a CO detector presented. CNS/LALD-D stated they understood the deficiency and would install a CO detector on the main level.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 0 780 | | |

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| 0 780 | Continued From page 30<br>days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>On December 17, 2024, at approximately 10:30 | 0 800 | | |

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| 0 800 | Continued From page 31<br><br>a.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D. The following was observed.<br><br>GENERAL MAINTENANCE<br>Water staining on the ceiling in the main level living room was present. CNS/LALD-D stated they had a leak above the ceiling in the past that was repaired.<br><br>The light fixture cover in the walk-in closet for bedroom 5 was missing. Survey staff explained the potential hazard an exposed light bulb presents. CNS/LALD-D stated they would install the light cover.<br><br>On December 17, 2024, at approximately 11:30 a.m., CNS/LALD-D stated they understood the above-listed deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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 | 0 810 | | |

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| 0 810 | Continued From page 32<br><br>evacuation.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 810 | | |

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| 0 810 | Continued From page 33<br><br>On December 17, 2024, at approximately 11:30 a.m., survey staff observed the fire evacuation diagrams indicated a designated exit through the office. The door to the office was locked and was not labeled as an exit.<br><br>On December 17, 2024, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br>The licensee's FSEP, failed to include the following:<br><br>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 the plan was designed for a building with life safety systems such as fire alarms and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.<br><br>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.<br><br>The FSEP included standard resident evacuation procedures but failed to provide specific | 0 810 | | |

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| 0 810 | Continued From page 34<br><br>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.<br><br>On December 17, 2024, at approximately 11:30 a.m., CNS/LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.<br><br>TRAINING:<br>The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, indicated staff were trained upon hire. No other training documentation was provided.<br><br>On December 17, 2024, at approximately 11:30 a.m., CNS/LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01370 SS=E | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne | 01370 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01370 | Continued From page 35<br><br>pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-B, ULP-G) | 01370 | | |

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| | 40267 | A. BUILDING: _____ B. WING _____ | 12/19/2024 |

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| 01370 | Continued From page 36<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>ULP-B was hired November 27, 2024, to provide direct care services.<br><br>On December 18, 2024, at 8:40 a.m., ULP-B was observed performing personal cares for R1.<br><br>ULP-B's employee record lacked evidence of the following:<br>Training:<br>- documentation requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the assisted living provider;<br>-basic infection control, including blood-borne pathogens;<br>-maintenance of a clean and safe environment;<br>-training on the prevention of falls for providers working with the elderly or individuals at risk of falls;<br>-medication, exercise, and treatment reminders;<br>-basic nutrition, meal preparation, food safety, and assistance with eating;<br>-preparation of modified diets as ordered by a licensed health professional; | 01370 | | |

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| 01370 | Continued From page 37<br><br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>-awareness of confidentiality and privacy;<br>-understanding appropriate boundaries between staff and residents and the resident's family;<br>-procedures to utilize in handling various emergency situations, and;<br>-awareness of commonly used health technology equipment and assistive devices.<br><br>Demonstration of Competency:<br>- appropriate and safe techniques in personal hygiene and grooming;<br>- hair care and bathing including;<br>- care of teeth, gums, and oral prosthetic devices<br>- care and use of hearing aids<br>- dressing and assisting with toileting, and;<br>- standby assistance techniques and how to perform them.<br><br>ULP-G<br>ULP-G was hired November 28, 2024, to provide direct care services.<br><br>On December 18, 2024, at 2:19 a.m., the surveyor observed ULP-G in the kitchen unpacking groceries.<br><br>ULP-G employee record lacked evidence of the following:<br>Training:<br>- documentation requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the assisted living provider;<br>-basic infection control, including blood-borne | 01370 | | |

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| 01370 | Continued From page 38<br><br>pathogens;<br>-maintenance of a clean and safe environment;<br>-training on the prevention of falls for providers working with the elderly or individuals at risk of falls;<br>-medication, exercise, and treatment reminders;<br>-basic nutrition, meal preparation, food safety, and assistance with eating;<br>-preparation of modified diets as ordered by a licensed health professional;<br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>-awareness of confidentiality and privacy;<br>-understanding appropriate boundaries between staff and residents and the resident's family;<br>-procedures to utilize in handling various emergency situations, and;<br>-awareness of commonly used health technology equipment and assistive devices.<br><br>Demonstration of Competency:<br>- appropriate and safe techniques in personal hygiene and grooming;<br>- hair care and bathing including;<br>- care of teeth, gums, and oral prosthetic devices<br>- care and use of hearing aids<br>- dressing and assisting with toileting, and;<br>- standby assistance techniques and how to perform them.<br><br>On December 19, 2024, at 1:27 p.m., clinical nurse supervisor/licensed assisted living direct (CNS/LALD)-D stated they were aware of the required trainings and required documentation of training for staff members providing direct care services. CNS/LALD-D stated ULP-B and ULP-G were new members to the assisted living facility | 01370 | | |

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| 01370 | Continued From page 39<br><br>(ALF) and they were behind on completing the trainings with staff.<br><br>The licensee's Staff Competency policy dated April 10, 2023, indicated residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. The policy indicated the CNS was responsible for assessment competency throughout the orientation process.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01380 SS=E | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by: | 01380 | | |

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| 01380 | Continued From page 40<br><br>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-B, ULP-G).<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>ULP-B was hired November 27, 2024, to provide direct care services.<br><br>On December 18, 2024, at 8:40 a.m., ULP-B was observed performing personal cares for R1.<br><br>ULP-B's employee record lacked evidence of the following:<br>Training:<br>-observation, reporting, and documenting of resident status;<br>-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and;<br>-recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>Demonstration of Competency: | 01380 | | |

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| 01380 | Continued From page 41<br><br>-reading and recording temperature, pulse, and respirations of the resident;<br>-range of motioning and positioning, and;<br>-administering medications or treatments as required.<br><br>ULP-G<br>ULP-G was hired November 28, 2024, to provide direct care services.<br><br>On December 18, 2024, at 2:19 a.m., the surveyor observed ULP-G in the kitchen unpacking groceries.<br><br>ULP-G's employee record lacked evidence of the following:<br>Training:<br>-observation, reporting, and documenting of resident status;<br>-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and;<br>-recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>Demonstration of Competency:<br>-reading and recording temperature, pulse, and respirations of the resident;<br>-range of motioning and positioning, and;<br>-administering medications or treatments as required.<br><br>On December 19, 2024, at 1:27 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they were aware of the required trainings and required training documentation for staff members providing direct care services. CNS/LALD-D stated ULP-B and ULP-G were new members to the assisted living | 01380 | | |

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| 01380 | Continued From page 42<br><br>facility (ALF) and they were behind on completing the trainings with staff.<br><br>The licensee's Staff Competency policy dated April 10, 2023, indicated residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. The policy indicated the CNS were responsible for assessment competency throughout the orientation process.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; | 01730 | | |

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| 01730 | Continued From page 43<br><br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of three residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include: | 01730 | | |

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| 01730 | Continued From page 44<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included bilateral (both) below the knee amputation, atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease (damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received assistance with medication management.<br><br>On December 17, 2024, at 11:12 a.m., the surveyor observed clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D apply nystatin powder to R1's groin area.<br><br>R1's signed Hospital Discharge Summary Notes dated November 25, 2024, indicated R1 was to receive the nystatin powder and to apply it topically (on the skin) "to affected area(s)" twice daily.<br><br>R1's medication administration record (MAR) for December 2024, indicated the nystatin powder was administered by unlicensed personnel (ULP)-B on December 14, 2024. R1's MAR lacked direction about what area of the body to apply the nystatin powder. | 01730 | | |

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| 01730 | Continued From page 45<br><br>R1's record lacked an individualized medication management record including documentation of specific resident instructions relating to the administration of medications.<br><br>On December 19, 2024, at 9:30 a.m., CNS/LALD-D stated they trained staff to apply the nystatin powder with each adult brief change and trained them to apply it to the groin area. CNS/LALD-D stated they were aware there had to be direction for staff members where to apply the nystatin powder. CNS/LALD-D stated the signed Discharge Summary Notes did not include the location of where to apply the nystatin powder. CNS/LALD-D stated R1 had not had a follow up with a primary care doctor since their discharge from hospital November 25, 2024, and was following the hospital discharge instructions.<br><br>The licensee's Prescriber Orders policy dated April 10, 2023, indicated medication orders would include the name of the medication, dosage, and the direction for use.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01750 SS=I | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated | 01750 | | |

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| 01750 | Continued From page 46<br><br>the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the unlicensed personnel (ULP) was able to demonstrate the ability to competently follow the procedure for two of three employees (ULP-B, ULP-G). This resulted in an immediate correction order on December 18, 2024.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On December 16, 2024, at 9:38 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated their hours were 8:00 a.m., until 5:00 p.m.<br><br>On December 17, 2024, at 8:27 a.m., in R1's bedroom, the surveyor observed a medication | 01750 | During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. | |

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| 01750 | Continued From page 47<br><br>cup on R1's nightstand that contained four medications. After feeding R1 orange juice, ULP-B administered the oral medications to R1. The only individuals present in R1's bedroom at the time of medication administration were R1, ULP-B, and the surveyor.<br><br>On December 18, 2024, at 8:32 a.m., the surveyor observed ULP-B administer oral medications to R1 in their bedroom. The only people present in R1's bedroom at the time of medication administration were R1, ULP-B, and the surveyor. There was no RN licensee staff member present at the time of medication administration.<br><br>ULP-B<br>ULP-B was hired November 27, 2024, to provide direct care services.<br><br>ULP-B's employee file contained a medication competency form. The undated, untitled competency form indicated there should have been three pages, however only two were present. The competency form lacked a signed competency testing by a registered nurse (RN) for medication administration.<br><br>ULP-G<br>ULP-G was hired November 28, 2024, to provide direct care services.<br><br>R1's medication administration record dated December 1, 2024, through December 31, 2024, indicated ULP-G administered oral medications to R1 at 8:00 p.m., on December 11, 2024, December 12, 2024, and December 13, 2024.<br><br>ULP-G's employee filed contained an undated medication competency form titled [licensee] 2.29 | 01750 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01750 | Continued From page 48<br><br>Oral Medications. The competency form had ULP-G's identifier on the top of the page. The document indicated there should have been two pages, however the second page was not present. ULP-G's record lacked evidence of a signed competency testing by a RN for medication administration.<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received assistance with medication administration.<br><br>R1's medication administration record (MAR) dated December 1, 2024, through December 31, 2024 indicated R1 received the following medications: pantoprazole 40 milligram (MG) 1 tablet once daily, aspirin 81 mg enteric coated 1 tablet once daily, warfarin 1 mg 1 tablet once daily, amoxicillin 500-125 mg 1 tablet twice daily, and nystatin powder apply topically to affected area two times daily.<br><br>On December 18, 2024, at 10:55 a.m., ULP-B stated they could only remember being trained on medication administration and operating the mechanical hospital bed. ULP-B stated they observed CNS/LALD-D administer medications to R1, and CNS/LALD-D observed ULP-B administer medications to R1.<br><br>On December 18, 2024, at 11:11 a.m., CNS/LALD-D stated their practice was to have ULPs observe them administer medications, then they would observe ULPs administer medications to residents. CNS/LALD-D stated they were still required to observe each medication | 01750 | | |

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| 01750 | Continued From page 49<br><br>administration by ULP-B, but their reasoning for not being present for the medication administration to R1 on December 17, 2024, and December 18, 2024, was because the surveyor was present. CNS/LALD-D stated when they were, "satisfied" with the ULP's performance related to medication administration, they would sign the competency paperwork. CNS/LALD-D stated ULP-B was "not 100 percent in passing medications", which was why the medication administration competency had not been signed.<br><br>On December 18, 2024, at 12:01 p.m., CNS/LALD-D stated ULP-G was not competent at administering medications to residents. CNS/LALD-D stated ULP-G was, "90 percent competent." CNS/LALD-D stated they did not co-sign with ULP-G for the administered medications to R1 and did not have documentation to establish CNS/LALD-D was present for each medication administration to R1. CNS/LALD-D stated they would consider ULP-G competent when they were able to administration medications without, "prompts, or asking questions." CNS/LALD-D stated ULP-B and ULP-G were still asking questions and still required prompts. CNS/LALD-D stated their plan was to sign the competencies for ULP-B and ULP-G when they were competent at medication administration.<br><br>On December 18, 2024, at 12:19 p.m., CNS/LALD-D stated there was no other documentation related to training for ULP-B and ULP-G. CNS/LALD-D all their training was verbal.<br><br>On December 18, 2024, at 2:24 p.m., ULP-G stated they provided direct cares to residents including medication administration. ULP-G stated CNS/LALD-D typically leaves around 5:00 | 01750 | | |

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| 01750 | Continued From page 50<br><br>p.m., but sometimes leaves earlier. ULP-G stated they had administered medications to R1 without another RN or CNS/LALD-D present in the facility.<br><br>The licensee's Staff Competency dated April 10, 2023, indicated the licensee's CNS was responsible for the overall competency evaluation program and staff members could not provide direct care services before successfully passing the competency evaluation.<br><br>MN Rules Part 4659.0190 Subp. 6. Training records and documentation indicates:<br>A. The facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic:<br>(1) facility name, location, and license number;<br>(2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training;<br>(3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation;<br>(4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and<br>(5) name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. | 01750 | | |

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| 01750 | Continued From page 51<br><br>B. Documentation of the completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training is completed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 01750 | | |
| 01950 SS=D | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's | 01950 | | |

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| 01950 | Continued From page 52<br>record for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included bilateral (both) below the knee amputation, atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease (damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received services including assistance with dressing, grooming, toileting, mobility with the Hoyer lift (patient lift device), meal preparation, medication administration, vital signs, housekeeping, and laundry.<br><br>R1's Hospital Documentation dated November | 01950 | | |

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| 01950 | Continued From page 53<br><br>20, 2024, page 18, included recommendations from speech language pathologist (SLP)-F; R1 required supervision when swallowing, seated fully upright and midline when eating, upright after eating for minutes (no total number of minutes was stated), small bites and liquid sips one at a time, warning signs included increased lung congestion, increased temperature, changes in voice quality (wet or gurgly sounding); increased difficulty with swallowing, and oral cares to include bristled toothbrush and oral cleaning solution (toothpaste).<br><br>R1's Treatment Administration Record (TAR) dated December 1, 2024, through December 31, 2024, indicated R1 required assistance with feeding. The document lacked SLP-F's recommendations.<br><br>On December 17, 2024, at 9:35 a.m., the surveyor entered R1's bedroom and observed unlicensed personnel (ULP)-B feeding R1. The headboard was elevated to approximately 45 degrees. ULP-B was feeding R1 a liquid from a bowl using a spoon. ULP-B stated they were trained by clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D to raise the head of the bed to the upright position or as much as R1 could tolerate. ULP-B stated they were trained to stop feeding if R1 started to cough, and to contact 911 or the RN if R1's cough persisted.<br><br>On December 17, 2024, at 9:45 a.m., CNS/LALD-D stated R1 could not lay flat while eating. CNS/LALD-D stated R1's headboard had to be set to a minimum of 45 degrees (so the resident was not lying flat). CNS/LALD-D stated they could not force R1 to be at 90 degrees (sat fully upright). CNS/LALD-D stated oral cares should be performed after each feeding. | 01950 | | |

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| 01950 | Continued From page 54<br><br>CNS/LALD-D stated they did not include that information on R1's TAR as they had trained staff directly on the positioning of R1 for feeding.<br><br>The licensee's Treatment and Therapy Management policy dated April 10, 2023, indicated licensee would use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01950 | | |
| 02290 SS=F | 144G.91 Subd. 2 Legislative intent<br><br>The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee limited the rights of the residents who resided in the facility when the licensee required residents to follow certain house rules. This had the potential to affect all resident residing in the assisted living facility.<br><br>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 | 02290 | | |

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| 02290 | Continued From page 55<br><br>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received services including assistance with dressing, grooming, toileting, mobility with the Hoyer lift (patient lift transfer assistance device), meal preparation, medication administration, vital signs, housekeeping, and laundry.<br><br>R1's medical record included a document titled "Lease Addendum for Crime-Free Alcohol/Beer/Illegal Drug-Free Housing" signed November 25, 2024. The document indicated "Possession and use of alcohol is not permitted on the premises." The addendum further indicated, "It is understood that a single violation shall be good cause for termination of the lease."<br><br>On December 17, 2024, at 1:23 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated residents could drink alcohol outside of the facility unless there was a prescriber's order not to drink. In addition, CNS/LALD-D stated the licensee would allow alcohol on the premises in moderation and the licensee could limit what they could bring into the facility and how much a resident could drink in the facility.<br><br>No further information was provided. | 02290 | | |

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| 02290 | Continued From page 56<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02290 | | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included bilateral (both) below the knee amputation, atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease | 02310 | | |

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| 02310 | Continued From page 57<br><br>(damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received assistance with dressing, grooming, toileting, mobility with the Hoyer lift (patient lift device), meal preparation, medication administration, vital signs, housekeeping, and laundry.<br><br>On December 16, 2024, at 10:33 a.m., during a facility tour, the surveyor observed R1 lying on a hospital bed with bilateral (two) bedrails. On the right-hand side bedrail was a label with the identifying mark, "Medline." On a separate label was the serial number, "SED24051202."<br><br>R1's record lacked evidence of the following information related to bilateral hospital bed rails:<br>-zone measurements of single hospital bedrail.<br><br>On December 17, 2024, at 1:11 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the bedrails were attached to the hospital bed when it arrived at the facility. CNS/LALD-D stated they were unaware the entrapment zones had to be measured and documented.<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate | 02310 | | |

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| 02310 | Continued From page 58<br><br>candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, Documentation about a resident's hospital-style bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Measurements;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.<br><br>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.<br><br>The licensee's Side Rail Use policy dated April 10, 2023, indicated the registered nurse (RN) will | 02310 | | |

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| 02310 | Continued From page 59<br>verify the side rails meet the FDA guidelines.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |
| 02320 SS=F | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to follow appropriate medication administration processes for one of one resident (R1). Additionally, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1).<br><br>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).<br><br>The findings include: | 02320 | | |

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| 02320 | Continued From page 60<br><br>R1 was admitted to the facility November 25, 2024, and began receiving assisted living services.<br><br>R1's diagnoses included atrial fibrillation (irregular heartbeat), mitral valve replacement (replaced valve of the heart), coronary artery disease (damaged arteries), coronary artery bypass graft (new veins are placed around the heart to bypass blocked vessels around the heart), ischemic cardiomyopathy (tissue death of the heart), single kidney removal, failure to thrive, and insulin dependent diabetic (unable to regulate blood sugar, needing additional insulin (hormone that regulates blood sugar) to maintain normal blood sugar levels).<br><br>R1's signed Service Plan dated November 25, 2024, indicated R1 received assistance with medication administration.<br><br>R1's medication administration record (MAR) dated December 1, 2024, through December 31, 2024, indicated R1 received the following medications:<br>-pantoprazole 40 milligram (mg) 1 tablet once daily,<br>-aspirin 81 mg enteric coated (for delayed absorption into the digestive track) 1 tablet once daily,<br>-warfarin 1 mg 1 tablet once daily,<br>-amoxicillin 500-125 mg 1 tablet twice daily, and<br>-nystatin powder apply topically to affected area two times daily.<br><br>On December 18, 2024, at 8:02 a.m., in the front common room on the main level of this three-level home, the surveyor observed unlicensed personnel (ULP)-B open the | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40267 | A. BUILDING: _____ B. WING _____ | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALNAS LODGE LLC | 2521 EDINBROOK TERRACE NORTH BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02320 | Continued From page 61<br><br>medication cart and prepare medications for R1. ULP-B unlocked the medication cart, removed a white binder that contained R1's MAR and a pillbox container labeled as belonging to R1. There were three rows labeled, "morn", "noon", and "night." Each row had a single box with the label, "Mon", "Tues", "Wed", "Thurs", "Fri", "Sat", and "Sun". ULP-B opened the single box labeled, "Wed" and dispensed four pills into a medication cup. Without accessing the MAR to verify the medications were correct, ULP-B placed the white binder and pillbox container back into the medication cart, locked it and placed the keys back in their pocket. ULP-B entered R1's room and approached R1. In the interest of safety, the surveyor intervened as the medications had not been verified by ULP-B.<br><br>On December 18, 2024, at 8:10 a.m., ULP-B stated they were trained to verify medications before administering them. ULP-B stated R1 always received four medications in the morning. ULP-B stated they did not verify the medications because they were already in a pillbox. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they trained staff to verify medications prior to administration and showed ULP-B the white binder. CNS/LALD-D explained to ULP-B they were required to verify the medications prior to the medication administration.<br><br>The licensee's Medication Administration policy dated April 10, 2023, indicated residents were entitled to safe administration of medications by qualified personnel.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40267 | A. BUILDING: _____ B. WING _____ | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALNAS LODGE LLC | 2521 EDINBROOK TERRACE NORTH BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02320 | Continued From page 62<br>days | 02320 | | |

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

Type: Full
Date: *12/16/24*
Time: 12:20:00
Report: 1043241368

# Food and Beverage Establishment Inspection Report



**Location:**
ALNAS LODGE LLC
2521 EDINBROOK TERRACE NORTH
Brooklyn Park, MN55443
Hennepin County, 27

**Establishment Info:**
ID #: 0043833
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: 12/31/24

**Operator:**

Phone #:
ID #:

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

The following orders were issued during this inspection.

**4-300 Equipment Numbers and Capacities**

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

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

NO FOOD THERMOMETER AVAILABLE. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER. COMPLY WITH ABOVE RULE.

*Comply By: 12/16/24*

**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 DISH MACHINE TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AN IRREVERSIBLE THERMOMETER OR THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F (150F FOR NSF) ON WEEKLY BASIS. COMPLY WITH ABOVE RULE.

*Comply By: 12/16/24*

**4-300 Equipment Numbers and Capacities**

***4-302.14*** ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PER STAFF, FACILITY USES CHLORINE SANITIZER. NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AND MAINTAIN CONCENTRATION BETWEEN 50-100 PPM. COMPLY WITH ABOVE RULE.

*Comply By: 12/16/24*

Type: Full
Date: *12/16/24*
Time: 12:20:00
Report: 1043241368
ALNAS LODGE LLC

# Food and Beverage Establishment Inspection Report

**6-500 Physical Facility Maintenance/Operation and Pest Control**

***6-501.11***

MN Rule 4626.1515 Maintain the physical facilities in good repair.

WALL PANEL NO LONGER FLUSH TO WALL SURFACE (DIRECTLY BEHIND KITCHEN SINK FAUCET). ADVISED STAFF TO REPAIR/REPLACE/RE-CAULK TO PREVENT FURTHER DAMAGE FROM WATER SPLASHES. COMPLY WITH ABOVE RULE.

*Comply By: 12/16/24*

**Surface and Equipment Sanitizers**

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

Inspection was completed with Keith Langley as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment and wooden cabinetry. Utensil surface temperature of dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***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.

***If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455***

Type: Full
Date: *12/16/24*
Time: 12:20:00
Report: 1043241368
ALNAS LODGE LLC

# Food and Beverage Establishment Inspection Report

**NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241368 of 12/16/24.

Certified Food Protection Manager: Amira Lateef

Certification Number: FM120927 Expires: 01/20/27

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Alade Hamza
Adminsstrator

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us