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

# NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

April 30, 2025

Licensee
HMN HOME HEALTHCARE LLC
3817 6th Street Northeast
Rochester, MN 55901

RE: Denial of License Number 416268
Health Facility Identification Number (HFID) 40786
Initial survey; Project Number(s) SL40786015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on April 2, 2025, survey on 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, Jodi Johnson, via email at: Jodi.Johnson@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 **May 3, 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 Jodi Johnson, Supervisor, at Jodi.Johnson@state.mn.us. Jodi Johnson can also be reached by office phone at 507-344-2730.

Sincerely,

Rick Michals, J.D.
**Executive Regional Operations Manager**

**Minnesota Department of Health**
**Health Regulation Division**

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40786 | A. BUILDING: _____ B. WING _____ | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HMN HOME HEALTHCARE LLC | 3817 6TH STREET NORTHEAST ROCHESTER, MN 55901 |

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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>SL40786015-0<br><br>On March 31, 2025, through April 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident; one receiving services under the provisional Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<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><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. | |
| 0 420 SS=F | 144G.40 Subdivision 1 Responsibility for housing and services | 0 420 | | |

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| 0 420 | Continued From page 1<br><br>The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. This had the potential to affect all 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 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>During the survey from On March 31, 2025, through April 2, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents.<br><br>The licensee had a provisional assisted living license effective April 2, 2024.<br><br>The licensee's "Provisional Assisted Living Licensure Information and Application", section | 0 420 | | |

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| 0 420 | Continued From page 2<br><br>titled "Official Verification of Owner or Authorized Agent", (page 17 and 18 of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract."<br><br>Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required."<br><br>Page 18 was electronically signed by the owner/agent on December 16, 2023.<br><br>As a result of this survey, the following orders were issued under 0480, 0485, 0550, 0580, 0630, 0660, 0680, 0690, 0730, 0810, 0900, 1370, 1380, 1440, 1470, 1610, 1620, 1640, 1650, 1700, 1730, 2290, 2320, and 3090, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 420 | | |

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| 0 480 | Continued From page 3 | 0 480 | | |
| 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 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; | 0 480 | | |

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| 0 480 | Continued From page 4<br><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.<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 April 1, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 | 0 480 | | |

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| 0 480 | Continued From page 5<br>hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 485 SS=C | 144G.41 Subdivision 1.a (a) Minimum requirements; required food services<br><br>All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect the licensee's one resident (R1).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected | 0 485 | | |

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| 0 485 | Continued From page 6<br>or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On March 31, 2025, at 12:00 p.m. during a tour of the facility, the surveyor did not observe any evidence of the facility's menu being posted or available to the licensee's resident.<br><br>On March 31, 2025, at 12:05 p.m., assistant living director in residency/house manager (ALDIR/HM)-A stated he had a menu on the computer but needed to print it out. ALDIR/HM-A further stated, "I know I need to have that."<br><br>The licensee's Food Service policy dated April 1, 2024, indicated menus are prepared one week in advance and made available to all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 485 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult | 0 550 | | |

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| 0 550 | Continued From page 7<br><br>Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. 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 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>On March 31, 2025, at 12:00 p.m. during a facility review of postings, the surveyor noted various postings on a bulletin board on the upper level of the facility. The postings lacked the required information about the licensee's grievance procedure, and the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. Furthermore, the licensee failed to post information for reporting suspected maltreatment to the Minnesota Adult Abuse | 0 550 | | |

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| 0 550 | Continued From page 8<br>Reporting Center as required.<br><br>On March 31, 2025, at 12:05 p.m., assisted living director in residency/house manager (ALDIR/HM)-A stated the information was not posted in a conspicuous location as required.<br><br>The licensee's Grievance policy dated April 1, 2024, indicated a copy of the grievance procedure is conspicuously posted in the residence with the facility with the following information:<br>- Name, phone number and email contact information for the individuals who are responsible<br>for handling resident complaints<br>- Contact information for the Minnesota Adult Abuse Reporting Center<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time | 0 580 | | |

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| 0 580 | Continued From page 9<br>of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect the licensee's one resident, 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 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>On March 31, 2025, at 10:45 a.m. during the entrance conference, assisted living director in residency/house manager (ALDIR/HM)-A stated the licensee had not yet started the process of a quality management program.<br><br>The licensee's Quality Improvement policy dated April 1, 2024, indicated the licensee has established a quality improvement program based on the organization ' s size and appropriate to the type of services provided to assure that effective, comprehensive and appropriate plans are operational for all residents within the organization.<br><br>No further information was provided. | 0 580 | | |

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| 0 580 | Continued From page 10<br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 580 | | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for the licensee's 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 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: | 0 630 | | |

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| 0 630 | Continued From page 11<br><br>R1<br>R1 began receiving assisted living services from the licensee on December 6, 2024.<br><br>R1's diagnoses included type 2 diabetes and depression.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, bathing, and dressing. R1's Service Plan lacked the service of medication administration.<br><br>On March 31, 2025, at 1:15 p.m., the surveyor observed assisted living director in residency/house manager (ALDIR/HM)-A administer diclofenac gel (a topical pain medication) to R1's left knee.<br><br>R1's Abuse Prevention Plan (APP) dated December 6, 2024, included the following areas of vulnerability:<br>-inability to ambulate safely; and<br>-inability to manage his own finances<br>The Abuse Prevention plan included interventions for the above; however, the plan also referenced the name of another facility.<br><br>R1's Abuse Prevention Plan included the name of another facility and did not properly reflect the licensee's/facility name (failing to ensure R1's IAPP was individualized). Furthermore, R1's APP lacked the required content to include:<br>-R1's susceptibility to abuse from others; and<br>-R1's susceptibility to abusing others including other vulnerable adults<br><br>On April 1, 2025, at 1:00 p.m., ALDIR/HM-A stated he found the Abuse Prevention Plan on the internet and thought it was ok to use as a template for the licensee's residents. | 0 630 | | |

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| 0 630 | Continued From page 12<br><br>ALDIR/HM-A did not edit it to properly identify the licensee's name. ALDIR/HM-A further stated he was not aware of the required content of an IAPP.<br><br>The licensee's Vulnerable Adult 1.16 policy dated April 1, 2024, indicated employees are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident.<br>An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided.<br>The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults.<br>2) The plan shall contain the resident's risk of abusing other vulnerable adults.<br>3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 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 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must | 0 660 | | |

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| 0 660 | Continued From page 13<br><br>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 maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a TB facility risk assessment, completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-D), and documentation of a completed health history and symptom screen for three of three employees (ULP-D, assisted living director in residency/house manager (ALDIR/HM)-A, and clinical nurse supervisor (CNS)-C).<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>FACILITY RISK ASSESSMENT<br>On March 31, 2025, at 10:45 a.m. during | 0 660 | | |

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| 0 660 | Continued From page 14<br><br>entrance conference, the surveyor requested the facility's TB risk assessment. ALDIR/HM-A stated the licensee had not completed one.<br><br>TB TESTING AND SYMPTOM SCREENING<br><br>ULP-D<br>ULP-D's employee record indicated a hire date of February 1, 2025, to provide direct care services to the licensee's residents.<br><br>ULP-D's record included a TB symptom screening dated June 1, 2024, and QuantiFERON gold blood test dated June 25, 2024; however, ULP-D's screening and blood test was not completed within 90 days of hire.<br><br>On April 1, 2025, at 1:10 p.m., ALDIR/HM-A stated he understood the TB blood test was acceptable for a year and did not know it was only acceptable for up to 90 days prior to date of hire.<br><br>ALDIR/HM-A<br>ALDIR/HM-A had a hire date of April 1, 2024, to provided direct care services to the licensee's residents.<br><br>On March 31, 2025, at 1:15 p.m., the surveyor observed ALDIR/HM-A administer a topical pain gel to R1.<br><br>ALDIR/HM-A's employee file included chest X-ray results dated March 13, 2023; however, his record lacked a TB symptom screening as required.<br><br>On April 1, 2025, at 1:10 p.m., ALDIR/HM-A stated he was not certain if he had completed a TB symptom screening and did not find one in his | 0 660 | | |

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| 0 660 | Continued From page 15<br>employee file.<br><br>CNS-C<br>CNS-C had a hire date of December 1, 2024, to provide nursing services for the licensee.<br><br>On April 1, 2025, at 8:15 a.m., the surveyor observed CNS-C to have brief contact with R1.<br><br>CNS-C's employee file included chest X-ray results dated January 29, 2021; however, his record lacked a TB symptom screening as required.<br><br>On April 2, 2025, at 7:10 p.m., CNS-C stated he had completed a TB symptom screening, and thought it was provided to the licensee.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.<br><br>The licensee's Tuberculosis Screening Prevention 4.14 policy dated April 1, 2024, | 0 660 | | |

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| 0 660 | Continued From page 16<br><br>indicated [licensee name] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements:<br>- Risk Assessment<br>- TB Screening<br>- Staff Education<br>The Director is responsible for conducting the formal TB Risk Assessment and updating it annually.<br>Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. Baseline screening includes an assessment for TB history and current TB symptoms.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 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 | 0 680 | | |

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| 0 680 | Continued From page 17<br><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 observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. 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 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 the residents).<br><br>The findings include:<br><br>On April 2, 2025, at 3:00 p.m., the surveyor reviewed the licensee's EP plan. The plan was found on assisted living in residency/house manager (ALDIR/HM)-A's computer and was not posted and available to the staff, residents or visitors. ALDIR/HM-A printed the EP plan for the | 0 680 | | |

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| 0 680 | Continued From page 18<br>surveyor's review.<br><br>The licensee lacked the following required information according to Emergency Preparedness: Appendix Z:<br>- the licensee had not completed a Hazard Vulnerability Assessment (the EP plan included the procedure to complete this, but it was not completed).<br>- the licensee had a missing resident plan; however, it was not in the EP plan and had not been reviewed on a quarterly basis;<br>- conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.<br>-evidence of resident and staff training on the facility's EP plan<br><br>On April 2, 2025, at 3:15 p.m., ALDIR/HM-A stated he had not conducted any drills or exercising of the EP plan, had not reviewed the missing resident procedure. ALDIR/HM-A indicated they were still working on the licensee's Emergency Plan and knew it was missing some content and had not completed a Hazard Vulnerability Assessment for the facility. In addition, ALDIR/HM-A indicated not being aware the missing resident policy/procedure required a review every 90 days. | 0 680 | | |

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| 0 680 | Continued From page 19<br><br>The licensee's Emergency Preparedness 1.17 policy dated April 1, 2024, indicated the 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. The plan will be posted prominently on each floor of the facility and will be reviewed on an annual basis. All staff members will be oriented on hire to the emergency preparedness plan and their associated responsibilities. Ongoing education will be provided to staff annually. Emergency and disaster training is offered to all residents annually. Documentation of the education is maintained. A disaster drill is conducted at the residence at least annually. Results of the drill will be documented.<br><br>The licensee's Missing Resident procedure dated April 1, 2024, indicated it will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 680 | | |
| 0 690 SS=C | 144G.43 Subdivision 1 Resident record<br><br>(a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.<br><br>This MN Requirement is not met as evidenced | 0 690 | | |

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| 0 690 | Continued From page 20<br><br>by:<br>Based on interview and record review, the licensee failed to ensure entries in the licensee's one resident record (R1) was authenticated by the title of the person making the entry.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1's Monthly, Daily Care Sheet dated March 1, 2025, through March 30, 2025, included the following tasks with either an "X" or "O" for completion by staff:<br>- shower<br>- brush teeth<br>- fresh clothing<br>- shampoo hair<br>- brush hair<br>- meals-breakfast, morning snack, lunch, afternoon snack, dinner, liquids<br>- activities-walk<br>- watch tv<br>- read<br>- games<br>- cleaning-clean bathroom<br>- clean floors<br>- empty garbage<br>- clean room<br>- make bed<br><br>The record did not include an indication of who entered the "X" or "O" and also did not include | 0 690 | | |

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| 0 690 | Continued From page 21<br>staff signatures with credentials/titles.<br><br>On April 2, 2025, at 7:48 p.m., assisted living director in residency/house manager (ALDIR/HM)-A stated he was looking to find an alternative documentation system to effectively document and include proper signature/staff credentials. ALDIR/HM-A further stated this was the form he found on the internet.<br><br>The licensee's Clinical Records policy dated April 1, 2024, indicated All entries into the clinical record will be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 690 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; | 0 730 | | |

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| 0 730 | Continued From page 22<br><br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<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 licensee's one resident record (R1) included the required content as required.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 730 | | |

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| 0 730 | Continued From page 23<br><br>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>R1's Service Plan dated December 10, 2024, indicated R1 received assistance with grooming, bathing, and dressing. R1's Service Plan lacked the service of medication administration.<br><br>On March 30, 2025, at 1:15 p.m., the surveyor observed assisted living director in residency/house manager (ALDIR/HM)-A administer a topical (on the skin) medication to R1.<br><br>R1's Monthly, Daily Care Sheet dated March 1, 2025, through March 30, 2025, included the following tasks with either an "X" or "O" for completion by staff:<br>- shower<br>- brush teeth<br>- fresh clothing<br>- shampoo hair<br>- brush hair<br>- meals-breakfast, morning snack, lunch, afternoon snack, dinner, liquids<br>- activities-walk<br>- watch tv<br>- read<br>- games<br>- cleaning-clean bathroom<br>- clean floors<br>- empty garbage<br>- clean room | 0 730 | | |

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| 0 730 | Continued From page 24<br>- make bed<br>The record lacked an indication of the frequency of each service and who completed the task.<br><br>On April 2, 2025, at 7:48 p.m., ALDIR/HM-A stated he was looking to find an alternative documentation system to effectively document and include proper information for the resident tasks as completed by staff. He stated this was the form he found on the internet.<br><br>The licensee's Clinical Records policy dated April 1, 2024, indicated the resident record would include documentation of services provided as identified in the service plan.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTIONS:<br>Twenty-one (21) days | 0 730 | | |
| 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 evacuation.<br>(c) Staff of assisted living facilities shall receive | 0 810 | | |

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| 0 810 | Continued From page 25<br><br>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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and failed to provide the required training and conduct evacuation drills. 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:<br><br>On April 1, 2025, at 2:52 p.m., the surveyor requested documents from assisted living director | 0 810 | | |

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| 0 810 | Continued From page 26<br><br>in residency/housing manager (ALDIR/HM)-A on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>ALDIR/HM-A was not able to provide any documentation of the FSEP. ALDIR/HM-A stated they had an evacuation map posted in the facility but did not have a written plan. FSEP must include an evacuation map showing the location and number of resident sleeping rooms, employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures for resident movement or evacuation during a fire or similar emergency including the identification of unique or unusual needs for movement or evacuation.<br><br>Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. ALDIR/HM-A stated they had not provided employee training.<br><br>Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. ALDIR/HM-A stated that they had not offered any resident training.<br><br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation of drills conducted or drills scheduled for a future date. ALDIR/HM-A stated | 0 810 | | |

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| 0 810 | Continued From page 27<br>they had not conducted any drills at the facility.<br><br>During an interview on April 1, 2025, at 2:52 p.m., ALDIR/HM-A stated they understood the areas of the plan that needed to be updated.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 900 SS=F | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br>(f) The resident must agree in writing to any additions or amendments to the contract. | 0 900 | | |

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| 0 900 | Continued From page 28<br><br>Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include the required content for the licensee's 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 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>R1 started receiving assisted living services on December 6, 2024.<br><br>R1's Service Plan dated December 10, 2024, indicated R1 received assistance with bathing, grooming, dressing, meals, and housekeeping. The Service Plan did not include the service of medication administration/management.<br><br>R1's record included the licensee's assisted living contract and was signed by R1 on December 10, 2024; however, the licensee failed to sign the contract.<br><br>On April 2, 2025, at 7:30 p.m., assisted living director in residency/house manager (ALDIR/HM)-A stated R1 was discharged from | 0 900 | | |

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| 0 900 | Continued From page 29<br><br>the hospital and admitted to the licensee and the day/move was chaotic. The next day, R1 was unsettled and wished to leave with his case manager to the crisis home he was familiar with. R1 returned to the facility several days later. ALDIR/HM-A was able to visit with R1 at the crisis home on December 10, 2024, and get the contract signed, but didn't realize it was not signed by the provider.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |
| 01370 SS=F | 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 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 | 01370 | | |

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| 01370 | Continued From page 30<br><br>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 for the required topics were completed by two of two unlicensed personnel (assisted living director in residency/house manager (ALDIR/HM)-A, (ULP)-D) prior to providing direct cares.<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: | 01370 | | |

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| 01370 | Continued From page 31<br><br>ALDIR/HM-A<br>ALDIR/HM-A had a hire date of April 1, 2024, and provided direct care services under the licensee's assisted living license.<br><br>On March 31, 2025, at 1:15 a.m., the surveyor observed ALDIR/HM-A administer medications to R1.<br><br>ALDIR/HM-A's employee file included training transcripts and courses completed with dates ranging from December 12, 2023, through June 12, 2024. There was no evidence the licensee's registered nurse (RN) completed a competency evaluation of the required topics.<br><br>ULP-D<br>ULP-D was hired on February 1, 2025, to provide direct care services under the licensee's assisted living license.<br><br>ULP-D's employee file included a training transcript from a previous Assisted Living employer dated July 2024. The training transcript included the required training topics; however, the licensee's RN did not ensure ULP-D received an evaluation for competency.<br><br>ALDIR/HM-A and ULP-D's record lacked evidence of competency (from the licensee's RN) prior to providing services for the following:<br>- appropriate and safe techniques in personal hygiene and grooming, including:<br>- hair care and bathing;<br>- care of teeth, gums, and oral prosthetic devices;<br>- care and use of hearing aids; and<br>- dressing and assisting with toileting;<br>- training on the prevention of falls; and<br>- standby assistance techniques and how to | 01370 | | |

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| 01370 | Continued From page 32<br>perform them<br><br>On April 2, 2025, at 7:30 p.m., clinical nurse supervisor (CNS)-C stated he completed medication training and competencies for ALDIR/HM-A and ULP-D; however, was not aware of the additional required competencies listed above.<br><br>On April 2, 2025, at 7:31 p.m., ALDIR/HM-A stated he was still trying to figure out the proper training forms to use for training documents.<br><br>The licensee's Staff Competency (2.14) policy dated April 1, 2024, indicated the Director and Clinical Nurse Supervisor are responsible for assessing competency throughout the orientation process.<br>Licensed health professionals, including nurses, may complete a competency evaluation (written and/or demonstration) in the following areas (refer to Competency Manual for criteria):<br>Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria.<br>Unlicensed personnel may not work for [licensee name] until they have successfully passed the written (at 80%) and demonstration competency evaluation.<br>- Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting<br>- Standby assistance techniques and how to perform them<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01370 | | |

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| 01370 | Continued From page 33<br>(21) days | 01370 | | |
| 01380 SS=F | 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:<br>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed by two of two unlicensed personnel (assisted living director in residency/house manager (ALDIR/HM)-A, (ULP)-D) prior to providing direct cares.<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 | 01380 | | |

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| 01380 | Continued From page 34<br><br>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>ALDIR/HM-A<br>ALDIR/HM-A had a hire date of April 1, 2024, and provided direct care services under the licensee's assisted living license.<br><br>On March 31, 2025, at 1:15 a.m., the surveyor observed ALDIR/HM-A administer medications to R1.<br><br>ALDIR/HM-A's employee file included training transcripts and courses completed with dates ranging from December 12, 2023, through June 12, 2024. There was no evidence the licensee's registered nurse (RN) completed a competency evaluation of the required topics.<br><br>ULP-D<br>ULP-D was hired on February 1, 2025, to provide direct care services under the licensee's assisted living license.<br><br>ULP-D's employee file included a training transcript from a previous Assisted Living employer dated July 2024. The training transcript included the required training topics; however, the licensee's RN failed to ensure ULP-D received an evaluation for competency.<br><br>ALDIR/HM-A and ULP-D's record lacked evidence of competency (from the licensee's RN) prior to providing services for the following:<br>- reading and recording temperature, pulse, and respirations of the resident;<br>- safe transfer techniques and ambulation; | 01380 | | |

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| 01380 | Continued From page 35<br>- range of motioning and positioning<br><br>On April 2, 2025, at 7:30 p.m., clinical nurse supervisor (CNS)-C stated he completed medication training and competencies for ALDIR/HM-A and ULP-D; however, was not aware of the additional required competencies listed above.<br><br>On April 2, 2025, at 7:31 p.m., ALDIR/HM-A stated he was still trying to figure out the proper training forms to use for training documents.<br><br>The licensee's Staff Competency (2.14) policy dated April 1, 2024, indicated the Director and Clinical Nurse Supervisor are responsible for assessing competency throughout the orientation process.<br>Licensed health professionals, including nurses, may complete a competency evaluation (written and/or demonstration) in the following areas (refer to Competency Manual for criteria):<br>- reading and recording temperature, pulse and respirations<br>- range of motion and positioning; and<br>- safe transfer techniques and ambulation<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living | 01440 | | |

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| 01440 | Continued From page 36<br><br>facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (assisted living director in residency/house manager (ALDIR/HM)-A and (ULP)-D) performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee.<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). | 01440 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HMN HOME HEALTHCARE LLC | 3817 6TH STREET NORTHEAST ROCHESTER, MN 55901 |

| (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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| 01440 | Continued From page 37<br><br>The findings include:<br><br>ALDIR/HM-A<br>ALDIR/HM-A had a hire date of April 1, 2024, and provided direct care services under the licensee's assisted living license.<br><br>On March 31, 2025, at 1:15 a.m., the surveyor observed ALDIR/HM-A administer medications to R1.<br><br>ALDIR/HM-A's employee file included various training documents including medication training and competency as signed by the facility registered nurse (RN).<br><br>ULP-D<br>ULP-D was hired on February 1, 2025, to provide direct care services under the licensee's assisted living license.<br><br>ULP-D's employee file included various training documents including medication training and competency as signed by the facility RN.<br><br>ALDIR/HM-A and ULP-D's employee files lacked evidence the licensee's registered nurse (RN) completed a 30-day supervision of delegated tasks.<br><br>On April 2, 2025, at 7:40 p.m., clinical nurse supervisor (CNS)-C stated he was not aware of the requirement for the 30-day RN supervision and had not completed one for any of the licensee's ULP.<br><br>The licensee's Supervision of Unlicensed Staff (4.6) policy dated April 1, 2024, indicated home health aides providing services to assisted living | 01440 | | |

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| 01440 | Continued From page 38<br><br>residents will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to the licensee's residents. Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, | 01470 | | |

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| 01470 | Continued From page 39<br>including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 01470 | | |

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| 01470 | Continued From page 40<br><br>review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, clinical nurse supervisor (CNS)-C) received orientation to assisted living facility licensing requirements and regulations before providing services.<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>ULP-D<br>ULP-D was hired on February 1, 2025, to provide direct care services under the licensee's assisted living license.<br><br>ULP-D's employee file included an orientation training checklist dated February 4, 2025.<br><br>ULP-D's record did not include evidence she received orientation to assisted living facility to include the following required content:<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure<br>- consumer advocacy services<br>- overview of Assisted Living Statutes<br>- a review of the types of Assisted Living services | 01470 | | |

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| 01470 | Continued From page 41<br>the employee will provide and the provider's scope of license<br><br>CNS-C<br>CNS-C was hired on December 1, 2024, to serve as the licensee's registered nurse.<br><br>CNS-C's employee file did not include evidence he completed/received orientation training at the time of hire.<br><br>On April 1, 2025, at 1:00 p.m., assisted living director/house manager (ALDIR/HM)-A stated he was still trying to find the proper training form to direct and reflect the accurate and required training and orientation topics.<br><br>On April 2, 2025, at 7:45 p.m., CNS-C stated he thought he completed some of the orientation training as required; however, he could not state which training was completed nor determine how the training was documented.<br><br>The licensee's Staff Orientation and Education (4.3) policy dated April 1, 2024, indicated upon hire and before providing service to residents, all employees attend a general orientation conducted by [licensee name] upon hire and before providing service to residents, all employees attend a general orientation conducted by [licensee name]. Those providing direct services will complete a competency evaluation as part of the orientation process.<br>Orientation is provided by the Clinical Nurse Supervisor or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional.<br>Orientation topics will include, but not be limited to, the following:<br>Upon hire and before providing service to | 01470 | | |

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| 01470 | Continued From page 42<br>residents, all employees attend a general orientation conducted by [licensee name]. Those providing direct services will complete a competency evaluation as part of the orientation process.<br>2. Orientation is provided by the Clinical Nurse Supervisor or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional.<br>3. Orientation topics will include, but not be limited to, the following:<br>a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659<br>b. Review of the employee's job description and responsibilities<br>c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person<br>d. Handling of emergencies and the use of emergency services<br>e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited 130<br>f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights<br>g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff<br>h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints<br>i. Consumer advocacy services, including Office of Ombudsman for Long-Term-Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human | 01470 | | |

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| 01470 | Continued From page 43<br><br>Services, and County Other advocacy services<br>j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 01470 | | |
| 01610 SS=F | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for the licensee's one resident (R1) prior to the initiation of services. | 01610 | | |

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| 01610 | Continued From page 44<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>R1 started receiving assisted living services on December 6, 2024.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, bathing, and dressing. R1's Service Plan lacked the service of medication administration.<br><br>R1's progress noted dated December 7, 2024, written by the registered nurse, indicated, "Patient seen for initial assessment. He is alert and oriented. He reports some minimal pain which he describes as mild. Pain gets worse his (sic) activity. He reports his mood as, "can be better".<br><br>R1's record included a comprehensive physical assessment dated December 17, 2024.<br><br>The licensee's registered nurse (RN) failed to complete a comprehensive assessment on or before the initiation of services (December 6, 2024), and failed to include the required content of a comprehensive RN assessment.<br><br>On April 1, 2025, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated he completed an assessment prior to R1's arrival to the facility; | 01610 | | |

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| 01610 | Continued From page 45<br><br>however, he documented the assessment as a clinical note and did not complete the comprehensive assessment tool to include all the required elements of a comprehensive assessment at that time.<br><br>The licensee's Assessment and Reassessment (2.3) policy dated April 1, 2024, indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01610 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. | 01620 | | |

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| 01620 | Continued From page 46<br><br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for the licensee's 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 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>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated he received services including assistance with grooming, bathing, and dressing. R1's Service Plan lacked the service of medication administration.<br><br>R1's progress noted dated December 7, 2024, written by the registered nurse, indicated, "Patient seen for initial assessment. He is alert and | 01620 | | |

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| 01620 | Continued From page 47<br><br>oriented. He reports some minimal pain which he describes as mild. Pain gets worse his (sic) activity. He reports his mood as, "can be better".<br><br>R1's record included a "Comprehensive Physical Assessment" dated December 17, 2024.<br><br>The licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days (due March 6, 2025).<br><br>On April 1, 2025, at 8:45 a.m. clinical nurse supervisor (CNS)-B stated he had been writing ongoing progress notes since R1's admission; however, he did not complete a 90-day comprehensive assessment when it would have been due (in March).<br><br>The licensee's Assessments and Reassessments policy dated April 1, 2024, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01620 | | |
| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The | 01640 | | |

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| 01640 | Continued From page 48<br><br>service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written 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 ensure a written service plan was revised to reflect the current services provided for the licensee's 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 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>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension. | 01640 | | |

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| 01640 | Continued From page 49<br><br>R1's Service Plan dated December 10, 2024, indicated R1 received assistance with grooming, bathing, bathing, meals, and housekeeping. R1's service plan lacked the service of medication administration.<br><br>On March 30, 2025, at 1:15 p.m. and April 1, 2025, at 7:45 a.m., the surveyor observed assisted living director in residency/house manager (ALDIR/HM)-A administer medications to R1.<br><br>The licensee failed to ensure the service of medication administration was included in R1's Service Plan.<br><br>On April 1, 2025, at 1:00 p.m., ALDIR/HM-A stated he did not realize R1's service of medication administration was missing from R1's service plan.<br><br>The licensee's Service Plan policy dated April 1, 2024, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan must be revised, if needed, based on resident review or reassessment<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to | 01650 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HMN HOME HEALTHCARE LLC | 3817 6TH STREET NORTHEAST ROCHESTER, MN 55901 |

| (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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| 01650 | Continued From page 50<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<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 service plan included all required content for the licensee's 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 | 01650 | | |

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| 01650 | Continued From page 51<br><br>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>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated R1 received assistance with brushing teeth, fresh clothing, bathing, shampoo hair, brush hair, meals (and snacks), activities, and housekeeping tasks. R1's service plan lacked the service of medication administration.<br><br>On March 30, 2025, at 1:15 p.m. and April 1, 2025, at 7:45 a.m., the surveyor observed assisted living director in residency/house manager (ALDIR/HM)-A administer medications to R1. ALDIR/HM-A further stated the licensee assisted with toileting, standby assistance with transfers, activities and meal prep/serving.<br><br>R1's service plan appeared as a template and lacked an indication to which of the above listed services were to be completed by staff.<br><br>R1's signed, Service Plan lacked the required content to include:<br>- the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>- the identification of staff or categories of staff who will provide the services;<br>- the schedule and methods of monitoring assessments of the resident; | 01650 | | |

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| 01650 | Continued From page 52<br><br>- the schedule and methods of monitoring staff providing services; and<br>- a contingency plan that includes:<br>- the action to be taken if the scheduled service cannot be provided;<br>- information and a method to contact the facility;<br>- the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>On April 1, 2025, at 1:00 p.m., ALDIR/HM-A stated he found a template from the internet and was using it as the service plan. ALDIR/HM-A further stated he was looking at moving to an electronic medical record system that would help him identify the required content of the service plan.<br><br>The licensee's Service Plan policy dated April 1, 2024, indicated the service plan includes the following:<br>a. A description of the services to be provided; the service description may be in the form of the resident ' s care plan developed with the resident/responsible party<br>b. The fees for services and the frequency of each service, according to the resident ' s current review or assessment and resident preferences<br>c. The identification of the staff or categories of staff who will provide the services<br>d. The schedule and methods of monitoring reviews or assessments of the resident | 01650 | | |

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| 01650 | Continued From page 53<br>e. The schedule and method of monitoring staff providing services**.<br>f. A contingency plan that includes the following<br>i. Action to be taken if the scheduled service cannot be provided<br>ii. Information and method for a resident or resident ' s representative to contact the facility<br>iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident ' s condition<br>iv. The identification of and information as to who has the authority to sign for the resident in an emergency<br>v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives<br>9. The service plan and revisions are entered into the clinical record, including notice of changes<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01700 SS=F | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include | 01700 | | |

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| 01700 | Continued From page 54<br><br>an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.<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) conducted a face-to-face medication management assessment to include all required content for the licensee's one resident (R1) receiving medication management services.<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>During the entrance conference on March 31, | 01700 | | |

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| 01700 | Continued From page 55<br><br>2025, at 10:50 a.m., assisted living director in residency/house manager (ALDIR/HM)-A confirmed the licensee provided medication management services to all the residents receiving assisted living services.<br><br>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, bathing, and dressing. R1's Service Plan lacked the service of medication administration.<br><br>On March 31, 2025, at 1:15 p.m., the surveyor observed ALDIR/HM-A administer a topical (on the skin) medication to R1's left knee.<br><br>R1's Medication Administration Record (MAR) dated March 2025, included two medications for high blood pressure, two for allergies, one supplement, one for depression, one for diabetes, two for sleep, one for high cholesterol, two oral medications for mild pain, one topical cream for mild pain, and two topical antifungal medications.<br><br>R1's Medication Assessment as found in R1's comprehensive RN assessment dated December 17, 2024, indicated R1 needed assistance with all routes of medication administration; however, it lacked evidence the assessment was conducted face-to-face with the resident. The assessment did not include an identification and review of all medications the resident was known to be taking, to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Furthermore, the assessment did not identify interventions needed in management of | 01700 | | |

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| 01700 | Continued From page 56<br><br>medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>On April 1, 2025, at 8:00 a.m., clinical nurse supervisor (CNS)-B, stated he used the assessment tool provided to him and was not familiar with all the required content of a medication assessment.<br><br>The licensee's Assessment of Medications policy dated April 1, 2024, indicated The RN will provide and document a face-to-face assessment with the resident. The assessment includes the following elements:<br>-Identification of the most accurate list of all medications the resident is taking, including the name, dosage, frequency and route<br>ii. Assessment of the following:<br>1. Indication for medications<br>2. Effectiveness of drug therapy<br>3. Side effects<br>4. Immediate desired effects<br>5. Unusual and unexpected effects<br>6. Actual or potential drug interactions<br>7. Duplicate drug therapy<br>8. Non-adherence with drug therapy<br>Resident preferences in how to take medications<br>- Interventions needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. The resident and resident's legal or designated representatives will be educated regarding interventions to manage the medications and prevent diversion. | 01700 | | |

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| 01700 | Continued From page 57<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01700 | | |
| 01730 SS=F | 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;<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 | 01730 | | |

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| 01730 | Continued From page 58<br><br>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 ensure an individualized medication management plan included all required content for the licensee's one resident (R1) who received medication services.<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>During the entrance conference on March 31, 2025, at 10:50 a.m., assisted living director in residency/house manager (ALDIR/HM)-A confirmed the licensee provided medication management services to all the residents receiving assisted living services.<br><br>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include | 01730 | | |

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| 01730 | Continued From page 59<br>depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, bathing, and dressing. R1's service plan lacked the service of medication administration.<br><br>On March 31, 2025, at 1:15 p.m., the surveyor observed ALDIR/HM-A administer a topical (on the skin) medication to R1's left knee.<br><br>R1's Medication Administration Record (MAR) dated March 2025, included two medications for high blood pressure, two for allergies, one supplement, one for depression, one for diabetes, two for sleep, one for high cholesterol, two oral medications for mild pain, one topical cream for mild pain, and two topical antifungal medications.<br><br>The licensee failed to develop a medication plan with the following required content:<br>- a statement describing the medication management services that will be provided;<br>- 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>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, | 01730 | | |

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| 01730 | Continued From page 60<br><br>verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>On April 1, 2025, at 8:00 a.m., clinical nurse supervisor (CNS)-B indicated he was not familiar with the requirement of a medication plan for the residents.<br><br>The licensee's Service Plan for Medication Management (3.3) policy dated April 1, 2024, indicated [licensee name] will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication. The written Medication Management Plan includes the following provisions:<br>- A statement describing the medication management services to be provided<br>- A description of the storage of medications based on the resident assessment and resident preference<br>- Risk of diversion<br>- Instructions per manufacturer<br>- Documentation procedures<br>- Procedures for medication reconciliation<br>- Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely<br>- Description of medication management tasks to be delegated to unlicensed personnel<br>- Plans for staff notifying the licensed health professional when/if a problem with medication management services arises<br>- Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions | 01730 | | |

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| 01730 | Continued From page 61<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 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 licensee's one resident (R1) when the licensee required residents to follow certain house rules.<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>R1 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, | 02290 | | |

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| 02290 | Continued From page 62<br><br>bathing, and dressing. R1's service plan lacked the service of medication administration.<br><br>R1's record included the licensee's undated, Rules and Expectations document and indicated the following restrictions:<br>- Absolutely no romantic or sexual involvement between residents/clients in [license name] is allowed.<br>- Houses are to remain gender specific with regard to visitation<br>- You will be sharing a bathroom and hot water heater with several other residents at one time; please be thoughtful of your house mates. Residents are not to take baths or extended showers.<br><br>Additionally, R1's Contract signed December 10, 2024, included Contract Termination verbiage indicating, "This contract maybe terminated by [licensee's name] for non-payment of services and/or rent, violating facility rules, physical or verbal aggression toward staff or other residents or if the resident's care expands beyond the scope of [licensee's name] services."<br><br>R1's record included an undated, Assisted Living Bill of Rights signed by R1, indicating the following:<br>- Subdivision 10. Individual Autonomy-Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact.<br>-Subdivision 12. Visitors and Social Participation-Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's | 02290 | | |

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| HMN HOME HEALTHCARE LLC | 3817 6TH STREET NORTHEAST ROCHESTER, MN 55901 |

| (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 |
|---|---|---|---|---|
| 02290 | Continued From page 63<br><br>choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.<br><br>On April 1, 2025, at 12:58 p.m., assisted living director in residency/house manager (ALDIR/HM)-A stated he "found" the house rules and expectations somewhere and just adapted them to this facility. He could not define/explain what "gender specific with regard to visitation", meant.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02290 | | |
| 02320 SS=D | 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 ensure delegated procedures were followed for the licensee's one resident (R1) observed during medication administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40786 | A. BUILDING: _____ B. WING _____ | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HMN HOME HEALTHCARE LLC | 3817 6TH STREET NORTHEAST ROCHESTER, MN 55901 |

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|---|---|---|---|---|
| 02320 | Continued From page 64<br><br>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 started receiving assisted living services on December 6, 2024, and had diagnoses to include depression, diabetes, and hypertension.<br><br>R1's Service Plan dated December 10, 2024, indicated he received assistance with grooming, bathing, and dressing. R1's service plan lacked the service of medication administration.<br><br>R1's Medication Administration Record (MAR) dated March 2025, included two medications for high blood pressure, two for allergies, one supplement, one for depression, one for diabetes, two for sleep, one for high cholesterol, two oral medications for mild pain, one topical cream for mild pain, and two topical antifungal medications.<br><br>R1's signed medication orders dated January 7, 2025, included diclofenac 1% gel, apply 4 grams (gm) to bilateral knees four times daily.<br><br>On March 31, 2025, at 1:15 p.m., the surveyor observed assisted living director in residency/house manager (ALDIR/HM)-A to administer a topical (on the skin) medication to R1's left knee. ALDIR/HM-A was observed to check the MAR, retrieve diclofenac gel 1% (identified as a tube of medication for pain) from R1's medication supply and enter R1's room. ALDIR/HM-A donned gloves and squirted an | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40786 | A. BUILDING: _____ B. WING _____ | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 02320 | Continued From page 65<br><br>undetermined amount of diclofenac gel to his gloved fingers and applied to R1's left knee. ALDIR/HM-A stated R1 declined the diclofenac gel to the right knee.<br><br>ALDIR/HM-A failed to properly measure the diclofenac gel to provide the correct amount (dose) of medication as ordered.<br><br>On March 31, 2025, at 1:20 p.m., ALDIR/HM-A stated R1's diclofenac gel came from the supply of medications R1 brought from his previous home/provider and did not include the designated measuring tool. ALDIR/HM-A stated he would work with the licensee's nurse to obtain the proper measuring tool.<br><br>The licensee's Medications Administration (3.4) policy dated April 1, 2024, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to the dose administered.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 02320 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>(a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision. | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40786 | A. BUILDING: _____ B. WING _____ | 04/02/2025 |

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|---|---|---|---|---|
| 03090 | Continued From page 66<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all three residents, staff, and visitors of the licensee.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Upon entrance to the facility on March 31, 2025, at 10:32 a.m., the surveyor observed the front entrance and entryway of the facility. No electronic monitoring signage was observed.<br><br>On March 31, 2025, at 12:05 p.m., assisted living director in residency/house manager (ALDIR/HM)-A stated he did not have electronic monitoring notice in place at this time as there were no actively used monitoring devices or cameras; therefore, he didn't feel he needed to have it posted.<br><br>The licensee's Electronic Monitoring policy dated April 1, 2024, indicated [licensee name] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and | 03090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 03090 | Continued From page 67<br>activities."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 03090 | | |

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *04/01/25*
Time: 09:04:39
Report: 1038251062

# Food and Beverage Establishment Inspection Report



**Location:**
HMN Home Healthcare LLC
3817 6th St NW
Rochester, MN55901
Olmsted County, 55

**Establishment Info:**
ID #: 0044244
Risk:
Announced Inspection: No

**License Categories:**

Expires on: 12/31/25

**Operator:**

Phone #: 9523569529
ID #:

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

The following orders were issued during this inspection.

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

REFRIGERATION UNIT IS RUNNING TO WARM (TOMATOES AT 45 DEGREES F.)
*Comply By: 04/14/25*

**4-700 Sanitizing Equipment and Utensils**

***4-703.11C*** ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

DISHWASHER DID NOT REACH APPROVED TEMPS
*Comply By: 04/14/25*

**2-100 Supervision**

***2-102.11DEFGHI*** ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation

and steps to be taken to ensure the points are controlled.

STAFF DID NOT SEEM TO BE KNOWAGABLE IN MANY OF THESE SUBJECTS SUCH AS (BUT LIMITED TO), FOOD TEMPS AND HAZARDS OF EATING RAW OR UNDERCOOKED EGGS.
*Comply By: 04/14/25*

**2-100 Supervision**
***2-102.12AMN***
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO ONE ON STAFF IS A CRMP.
*Comply By: 04/14/25*

**4-200 Equipment Design and Construction**
***4-201.11***
MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

CABINET TOPS ARE MADE OUT OF FORMICA AND SOME OF THE ARE CHIPPED
*Comply By: 04/14/25*

**4-600 Cleaning Equipment and Utensils**
***4-601.11C***
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

MICRO WAVE IS DIRTY, STOVE IS DIRTY, COUNTER IS DIRTY
*Comply By: 04/14/25*

**Food and Equipment Temperatures**

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: Tomato
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

COOLING UNIT WAS TURNED DOWN TO BRING COOLING UNIT TEMP DOWN TO APPROVED LEVELS.

STAFF WILL USE DISHWASHER TO WASH DISHES THEN SANITIZE DISHES IN ONE OF THE SINKS AND AIR DRY DISHES UNTIL DISHWASHER IS REPAIRED.

Type: Full
Date: *04/01/25*
Time: 09:04:39
Report: 1038251062
HMN Home Healthcare 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 1038251062 of 04/01/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
Establishment Representative

Signed:_____

Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us