Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 20, 2023

Licensee
Heritage Haven Inc
3042 Morris Thomas Road
Duluth, MN 55811

RE: License Number 412185
Health Facility Identification Number (HFID) 25455
Project Number(s) SL25455015

Dear Licensee:

On December 13, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 1, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 20, 2023.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 1, 2023, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on September 1, 2023, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (a) / 626.557, Subd. 3
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 -$500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on December 13, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 13, 2023, we identified the following violation(s):

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0900-Contract Required-144g.50 Subdivision 1

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

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

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

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRD-Appeals-Form

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

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

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

Sincerely,

Maria King, RN
Division Director

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
	25455	A. BUILDING: _____ B. WING _____	R 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL25455015-1 On December 12, 2023, through December 13, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 13, 2023. At the time of the survey, there were 28 residents receiving services under the Assisted Living with Dementia care license. As a result of the revisit, the following orders were reissued and issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	{0 620}		

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

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{0 620}	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for one of two residents (R17). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R17 was admitted February 29, 2012.	{0 620}		

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{0 620}	Continued From page 3 R17's diagnoses included degenerative arthritis, hypothyroidism (low thyroid level), and osteopenia (weakened bones). R17's Service Plan dated October 19, 2023, indicated R17 received assistance with medication management, dressing, grooming, bathing, housekeeping and laundry. R17's progress note dated October 17, 2023, indicated R17 had a fall in her bedroom attempting to transfer self from recliner to wheelchair. R17 was found on left side and blood noted from R17's head. A rounding care provider was at the facility, assessed R17 and instructed R17 to be evaluated in the emergency room. R17's Fall Scene Investigation Report dated October 17, 2023, indicated R17 had an unwitnessed fall in her room on October 17, 2023, at 10:30 a.m. R17 obtained a head laceration and was sent to the emergency room for evaluation. R17's MAARC report was filed on October 19, 2023, at 9:50 p.m., by LALD-A. R17's MAARC report indicated on October 17, 2023, at 10:45 a.m., R17 attempted to self transfer in her room, lost her balance and fell. R17's chair alarm alerted staff and found R17 lying on the floor. Rounding nurse practioner was present and examined R17 and directed staff to send R17 to the emergency room due to blood coming from the right side of R17's head. R17 was seen in the emergency room for laceration to the right side of head and R17 obtained three staples to close the wound. On December 13, 2023, at 11:37 a.m., LALD-A stated all staff have been trained and educated	{0 620}		

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{0 620}	Continued From page 4 on when and an how to file a MAARC report and would report any suspected abuse or neglect immediately or within 24 hours. LALD-A stated a MAARC report was not immediately filed after R17 received treatment for a head injury from her fall and LALD-A stated she did not think a MAARC report was needed. LALD-A stated a MAARC report was not filed until she was directed by the licensee's registered nurse (RN) consultant a MAARC report was needed since R17 obtained a significant injury resulting from an unwitnessed fall that required emergency care and treatment. The licensee's Vulnerable Adult Maltreatment policy dated November 7, 2023, indicated any staff person who witness or suspects maltreatment of a vulnerable adult would report the incident immediately to LALD-A or the registered nurse on call, and that person would complete an incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, LALD-A or the RN would immediately make a report. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report would be made to the CEP. No further information was provided.	{0 620}		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 5 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed for one of one unlicensed personnel (ULP)-M, who obtained housing by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 12, 2023, at 11:27 a.m., during the facility tour ULP-D stated ULP-M resided in building one and ULP-M had lived at the facility for a few months. On December 12, 2023, at 11:53 a.m., licensed assisted living director (LALD)-A stated ULP-M was the housing manager and lived on the premises in the attached apartment of building one's assisted living building. On December 12, 2023, at 11:55 a.m., licensed practical nurse (LPN)-C stated ULP-M was	0 630		

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0 630	Continued From page 6 identified as the housing coordinator for the facility and ULP-M had lived in building one for two weeks. ULP-M had a hire date of March 22, 2022, to provide direct care services. ULP-M's employee file lacked evidence an IAPP was developed. On December 13, 2023, at 11:32 a.m., LALD-A stated the licensee had not develop an IAPP for ULP-M and was unaware of the requirement. The licensee's Individual Abuse Prevention Plans policy dated November 19, 2023, indicated an Individual Abuse Prevention Plan would be developed for each assisted living resident to include: -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; -resident's risk of abusing other vulnerable adults; -specific measures to minimize the risk of abuse to that person and other vulnerable adults; and -measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	{0 680}		

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

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{0 680}	Continued From page 8 The findings include: On December 12, 2023, from 11:08 a.m. through 12:03 p.m., the surveyor toured all three buildings with unlicensed personnel (ULP)-D, ULP-G, and ULP-N. The surveyor, ULP-D, ULP-G, and ULP-N did not observe signage posted or information regarding the licensee's EPP in the common areas of any of the three buildings. On December 12, 2023, at 12:09 p.m., licensed assisted living director (LALD)-A stated the licensee had not posted the EPP in a prominent area in any of the three buildings. The licensee's undated EPP provided to the surveyor lacked the following: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - subsistence needs for staff and residents during an emergency to include (food, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - emergency staffing strategies to include volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for ombudsman; - primary and alternative means for	{0 680}		

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{0 680}	Continued From page 9 communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On December 12, 2023, at 2:30 p.m., the surveyor reviewed the missing and generic EPP policies and procedures with LALD-A. LALD-A stated the EPP is a work in progress and is continuing to be updated specific to the licensee. The licensee's undated Emergency Preparedness Disaster Plan policy indicated the EPP is a written plan based upon a comprehensive, all-hazards approach to meet the health and safety needs of the residents. The plan (EPP) is intended to meet and maintain a safe and secure environment for all within (licensee's name), provide a plan to sustain (licensee's name) critical functions, and maintain operational integrity. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	{0 780}		

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{0 780}	Continued From page 10 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 780}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 780}	Continued From page 11 On a facility tour on December 12, 2023, at 12:30 p.m., with maintenance (M)-H, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit number 3044. The smoke alarm test button was activated in resident room 3 by M-H accompanying on the tour and the alarm sounded only in resident room 3. Resident room 3 smoke alarm was not interconnected to sound all alarms throughout the facility including outside in the immediate vicinity of the resident rooms in the hallway. During the tour M-H also activated a smoke alarm test button at the opposite end of the building indicating the smoke alarms in resident room number 3 and outside in the immediate vicinity of the resident rooms in the hallways did not sound and were not interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit including outside in the immediate vicinity of the resident rooms in the hallway. During the tour the smoke alarms were tested and M-H, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. M-H stated he thought he had fixed the alarms to be interconnected and upon testing realized they were not fixed.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	R 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

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{0 810}	Continued From page 12 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training. This had the potential to directly affect all residents, staff, and visitors.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810}	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2023, at 12:30 p.m., maintenance (M)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents evident by not including fire protection actions necessary for residents in writing in the plan. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include unique and unusual needs of individual residents for evacuation. During an interview on December 12, 2023, at 12:30 p.m., M-H stated the facility hired a consultant to help add this information to the FSEP, but it has not been completed yet.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810}	Continued From page 14 TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the training for residents has been completed. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the training for employees has been completed. During an interview on December 12, 2023, at 12:30 p.m., M-H stated his staff would send the surveyor via email the records for employee and resident training. No training records were received.	{0 810}		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 15 documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract/rental agreement with the required content for one of one unlicensed personnel (ULP)-M, who obtained housing by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 12, 2023, at 11:27 a.m., during the facility tour ULP-D stated ULP-M resided in building one and ULP-M had lived at the facility for a few months.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 16 ULP-M had a hire date of March 22, 2022, to provide assisted living services. ULP-M's employee file lacked evidence a written lease agreement by the licensee for housing was implemented. On December 12, 2023, at 11:53 a.m., licensed assisted living director (LALD)-A stated ULP-M was the housing manager and lived on the premises in the attached apartment of building one's assisted living building. LALD-A stated the licensee did not have a rental/lease agreement for ULP-M and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Follow-Up
Date: *10/24/23*
Time: 11:30:00
Report: 1016231145

Food and Beverage Establishment Inspection Report

Location:

Heritage Haven Inc - Building 1
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
ID #:

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

No NEW orders were issued during this inspection.

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

COMMENTS:

THIS WAS A FOLLOWING UP INSPECTION.

ALL ORDERS HAVE BEEN CLEARED.

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 1016231145 of 10/24/23.

Certified Food Protection Manager: DIANCE J. HOLMBERG

Certification Number: FM105311 Expires: 02/09/24

Signed: _____
DIANE J. HOLMBERG
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Follow-Up
Date: *10/24/23*
Time: 11:50:00
Report: 1016231147

Food and Beverage Establishment Inspection Report

Location:

Heritage Haven Inc - Building 2
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
ID #:

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

No NEW orders were issued during this inspection.

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

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION.

ALL ORDERS HAVE BEEN CLEARED.

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 1016231147 of 10/24/23.

Certified Food Protection Manager: DIANE J. HOLMBERG

Certification Number: FM105311 Expires: 02/09/24

Signed: _____
DIANE J. HOLMBERG
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Follow-Up
Date: *10/24/23*
Time: 11:45:00
Report: 1016231146

Food and Beverage Establishment Inspection Report

Location:

Heritage Haven Inc - Building 3
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
ID #:

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

No NEW orders were issued during this inspection.

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

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION.

ALL ORDERS HAVE BEEN CLEARED.

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 1016231146 of 10/24/23.

Certified Food Protection Manager: DIANE J. HOLMBERG

Certification Number: FM105311 Expires: 02/09/24

Signed: _____
DIANE J. HOLMBERG
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 27, 2023

Licensee
Heritage Haven Inc.
3042 Morris Thomas Road
Duluth, MN 55811

RE: Conditional License Number 412185
Health Facility Identification Number (HFID) 25455
Project Number(s) SL25455015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 1, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **December 26, 2023**.

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

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

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

Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

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

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

b. **No new admissions:** Heritage Haven Inc. will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Heritage Haven Inc. must provide the Department:

i. A list of the names and birthdates of any individuals Heritage Haven Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

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

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Heritage Haven Inc. and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Survey Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;

iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

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

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

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Heritage Haven Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Heritage Haven Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Heritage Haven Inc's assisted living facility license, and Heritage Haven Inc. will correct violations identified during the survey to come into substantial compliance. If MDH determines Heritage Haven Inc. is not in substantial compliance, MDH may take additional

enforcement action against Heritage Haven Inc., including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. The request for hearing should be addressed to:

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

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25455015-0 On August 29, 2023, through September 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 25 residents receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on August 30, 2023, issued for SL25455015-0, tag identification 2310. Immediacy of correction order 2310 was not removed as of survey exit on September 1, 2023.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 10, 2023, at 3:30 p.m. during pre-survey preparation, the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated LALD-A had an assisted living director license (effective May 6, 2021; expires October 31,2023). The website did not indicate LALD-A as the Director of Record for the licensee, this section was left blank. During the entrance conference on August 29, 2023, at 11:11 a.m., LALD-A identified herself as the current LALD for the licensee. The surveyor reviewed the BELTSS website with LALD-A. LALD-A confirmed the BELTSS website did not indicate LALD-A as the Director of Record for the	0 110		

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0 110	Continued From page 2 licensee. LALD-A stated she was unaware the Director of Record needed to be listed on the BELTSS website. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250		

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0 250	Continued From page 3 access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 250		

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0 250	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.	0 250		

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0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.	0 250		

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0 250	Continued From page 6 - 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. - 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. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on March 31, 2023. The licensee had an assisted living license issued on May 1, 2023, with an expiration date of April 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;	0 250		

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0 250	Continued From page 7 (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (6) medication and treatment management; (7) delegation of tasks by registered nurses or licensed health professionals; and (8) supervision of registered nurses and licensed health professionals. On September 1, 2023, at 3:30 p.m., LALD-A confirmed the licensee provided assisted living with dementia care but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0250, 0450, 0470, 0480, 0485, 0550, 0570, 0580, 0620, 0640, 0650, 0680, 0780, 0790, 0800, 0810, 0820, 0910, 0930, 0940, 0950, 1060, 1290, 1370, 1470, 1500, 1540, 1550, 1620, 1650, 1750, 1760, 1770, 1880, 1890, 1940, 1960, 2040, 2140, 2310, 3000 and 3090, indicating the	0 250		

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0 250	Continued From page 8 licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living to three of four residents (R1, R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 450		

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0 450	Continued From page 9 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted for services on June 6, 2023. R1's record indicated R1 received the Combined Federal and State Home Care Bill of Rights signed June 6, 2023. R1's record lacked evidence R1 had received the Assisted Living Bill of Rights. R4 R4 admitted for services on April 6, 2022. R4's record indicated R4 received the Combined Federal and State Home Care Bill of Rights, revised November 2019, on April 6, 2022. R4's record lacked evidence R4 had received the Assisted Living Bill of Rights. R6 R6 was admitted for services on February 8, 2022. R6's record indicated R6 received the Combined Federal and State Home Care Bill of Right signed February 8, 2022. R6's record lacked evidence R1 had received the Assisted Living Bill of Rights. On September 1, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated R4 and all	0 450		

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0 450	Continued From page 10 other residents received the combined Federal and State Home Care Bill of Rights at the time of admission. The licensee's Bill of Rights policy dated August 9, 2023, indicated the licensee would provide each resident with the Assisted Living Bill of Rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable	0 470		

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0 470	Continued From page 11 amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 33 and had a current census of 25 residents. During the entrance conference on August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A stated the licensee had not developed a staffing plan or posted a staff schedule in any of the three buildings. LALD-A stated the usual staffing schedule for the licensee was as follows: -clinical nurse supervisor (CNS)-B was on site	0 470		

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0 470	Continued From page 12 four days a week; -registered nurse (RN)-J was on site two days a week; -licensed practical nurse (LPN)-C was on site four days; -the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m. to 2:00 p.m. -the evening shift was staff with two ULPs from 2:00 p.m. to 8:30 p.m., and one ULP from 8:30 p.m. to 10:00 p.m.; and -the night shift was staffed with one ULP from 10:00 p.m. to 6:00 a.m. On August 29, 2023, at 10:15 a.m., during a tour of the facility with ULP-D the surveyor did not observe a staff schedule posted in any of the licensee's three buildings. The licensee's Staffing and Scheduling policy dated August 9, 2023, indicated the clinical nurse supervisor would develop a written staffing plan that provided and adequate number of qualified direct-care staff to meet the residents' needs 24-hour a day, seven-days a week. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of the facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 13 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Reports dated August 29, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 485		

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0 485	Continued From page 14 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: 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 all 25 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 10:15 a.m., during a tour of the buildings with ULP-D, the surveyor did not observe a menu posted in any of the three buildings. ULP-D confirmed menus were not posted or provided to the residents.	0 485		

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0 485	Continued From page 15 On August 29, 2023, at 11:11 a.m., during entrance conference with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C, LALD-A stated weekly menus were not posted or provided to the residents. The licensee's Menu policy date August 9, 2023, indicated menus must be prepared at least one week in advance, and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced	0 550		

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	25455	A. BUILDING: _____ B. WING _____	09/01/2023

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0 550	Continued From page 16 by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 10:15 a.m., the surveyor observed and confirmed, with unlicensed personnel (ULP)-D, the licensee's grievance procedure was not posted with the required content to indicate the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances in any of the three (3) buildings. On August 29, 2023, at 11:11 a.m., during entrance conference with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C confirmed the licensee's grievance procedure was not posted in any of the buildings and was not aware of the requirement. The surveyor requested a copy of the licensee's complaint procedure. The licensee's Complaint procedure provided dated July 5, 2023, did not include the following required content: -the telephone number, email contact information for the individuals who are responsible for	0 550		

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0 550	Continued From page 17 handling resident grievances; and -the following contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. CNS/LALD-A stated the above noted information. The licensee's Complaint policy dated July 5, 2023, indicated the licensee would post, in a conspicuous place, information about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling the complaint/grievances. The postings would also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level one violation (a	0 570		

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0 570	Continued From page 18 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 10:15 a.m., during a tour of the three buildings with unlicensed personnel (ULP)-D, the surveyor observed, and ULP-D confirmed the facility's license was posted in building one in the main office, in building two on the cork board of the desk in the office, and no licensed was observed posted in house three. On August 29, 2023, at 11:11 a.m., during entrance conference with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C. LALD-A stated the licenses were not posted at the main entrances of the buildings and thought each house had a license posted in each of the offices. The licensee's Assisted Living License and Posting policy dated August 9, 2023, indicated the licensee would maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license would be posted at the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		

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0 580	Continued From page 19	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 11:11 a.m., during entrance conference with licensed assisted living	0 580		

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0 580	Continued From page 20 director (LALD)-A and licensed practical nurse (LPN)-C. The surveyor requested documentation of the licensee's quality management activities. LALD-A stated the licensee did not have formal quality management meetings and met with the staff monthly and the nurses every other month. LALD-A stated the registered nurse completed Quality Assurance Documentation for each resident monthly but did not have any current improvement projects the licensee was working on related to the residents or resident care. The licensee had not developed a Quality Management policy at the time of the surveyors' request and later provided the following policy: The licensee's Quality Management Project dated September 12, 2023, indicated the licensee would have at least one documented quality management project in place at all times, and retain records such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 620		

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0 620	Continued From page 21 review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R6) who had incidents of elopement and for one of one resident (R1) who had a significant injury with a fall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 29, 2023, at 11:11 a.m., the evaluator licensed asked assisted living director (LALD)-A if the licensee had any elopements in the past six months. LALD-A stated a resident in house one recently left the premises and was brought back to the facility by the police. LALD-A stated she did not file a MAARC report and was unaware the elopement incident required a MAARC report. LALD-A stated the licensee initiated a resident search, the police were notified, and family was updated. The surveyor requested MAARC and incident reports for the last six months to review. R6 R6 was admitted February 8, 2022. R6's diagnoses included dementia. R6's Service Plan dated February 8, 2022, indicated R6 required assistance with dressing,	0 620		

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0 620	Continued From page 22 grooming, bathing, medications management, TED (thromboembolic deterrent (compression) stockings, safety checks, housekeeping and laundry. R6's Progress Notes indicated on July 30, 2023, at 8:00 a.m., staff noticed R6 was not in her room, other staff were alerted and a search inside and outside of the buildings was initiated. LALD-A was notified, and LALD-A notified the police. At 8:20 a.m., R6 was brought back to the facility by the police. R6's Progress Note dated August 30, 2023, at a late entry indicted RN-J received a call from LALD-A and informed R6 had eloped from the facility and was brought back to the facility by the police. LALD-A directed RN-J to call and notify R6's daughter. R6's Minnesota Adult Abuse Reporting Center report was filed August 30, 2023, at 11:55 a.m., by LALD-A after the surveyor requested all MAARC reports for the last six months during the entrance conference on August 29, 2023, at 11:15 a.m. R6's MAARC report indicated on July 30, 2023, at 8:00 a.m., LALD-A received a call at 8:05 a.m., reporting staff was unable to locate R6 in the building. Staff searched for R6 on the premises and the surrounding area by car. LALD-A notified the police and LALD-D was informed by the dispatcher a neighbor reported R6 was observed standing outside and to the north of the facility. The neighbor had called the police and the police brought R6 to her previous address. 911 dispatch notified the police the licensee reported R6 was a missing and the police brought R6 back to the facility at 8:20 a.m. R1	0 620		

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0 620	Continued From page 23 R1 was admitted June 6, 2023. R1's diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dementia. R1's Service Plan dated June 8, 2023, indicated R1 required assistance with dressing, grooming, toileting, bathing, transferring, medication management, blood glucose monitoring, housekeeping and laundry. R1's Fall Incident Reports indicated on June 16, 2023, at 8:00 a.m., R1 was found on the floor, on his stomach, wrapped in blanket after attempting to self-transfer into his bed. R1's left thumb was swollen and R1 complained of pain. R1 was sent into the emergency department for evaluation and was diagnosed with a fracture to his left thumb. R1's record lacked evidence a MAARC report was filed after R1 obtained a fracture after a fall. On September 1, 2023, at 1:06 p.m., LALD-A stated she did not file a MAARC report at the time of R6's elopement or for R1's fracture from a fall. LALD-A stated she was unaware MAARC reports needed to be filed for injuries even though the injury was from a fall and it was determined the was an accident. The licensee's Vulnerable Adult, Maltreatment and Reporting policy dated April 15, 2022, indicated staff would immediately report suspected allegations of abuse, neglect or financial exploitation to MAARC. Immediately means as soon as possible, from the time the initial knowledge of the initial incident occurred. No further information was provided.	0 620		

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0 620	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas including: posting the 911 emergency number and contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 640		

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0 640	Continued From page 25 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 29, 2023, at 10:10 a.m., with unlicensed personnel (ULP)-D, the surveyor did not observe the required postings of 911 emergency number or MAARC contact information in any of the three buildings near the public cordless. During entrance conference on August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A stated the registered nurse made print outs with contact information for 911 and MAARC and posted in each of the buildings. LALD-A confirmed in building two there was no 911 or MAARC information posted by the cordless phone in the kitchen. LALD-A stated the signs must have been taken down. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 26 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of five employee records (clinical nurse supervisor (CNS)-B, licensed practical nurse (LPN)-C) contained a current job description. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-B CNS-B was hired on December 7, 2021, to provide supervision and direct care services under the licensee's Assisted Living with	0 650		

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0 650	Continued From page 27 Dementia Care license. Throughout the survey, the surveyor observed CNS-B supervise unlicensed personnel (ULP) and provide direct care services to residents. CNS-B's employee record contained a job description for a certified nursing assistant. LPN-C LPN-C started employment on August 8, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey, the surveyor observed LPN-C provide assisted living services. LPN-C's employee record lacked a current job description. On September 1, 2023, at 10:10 a.m., licensed assisted living director (LALD)-A stated CNS-B and LPN-C's employee records lacked a current job description. The licensee's Employee Records policy dated August 9, 2023, indicated employee records for each person would include a current signed job description which includes qualifications, responsibilities, and identification of supervisors, if any. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 680	Continued From page 28	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 29 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 10:15 a.m., the surveyor toured all three buildings with unlicensed personnel (ULP)-H. The surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the buildings. During entrance conference on August 29, 2023, at 11:11 a.m., with licensed assisted living director (LALD)-A stated she was responsible for developing and maintaining the licensee's the EPP. LALD-A stated the EPP was in the policy and procedure binder in the nurses' offices. LALD-A confirmed the licensee's EPP was not prominently posted in any of the three buildings. The licensee's EPP dated August 2, 2023, provided to the surveyor included generic instructions for staff to follow in case of a fire, severe weather, and an evacuation. The licensee's EPP lacked the following: - a completed HVA - policies and procedures to address natural and man-made disasters; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee;	0 680		

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	25455	A. BUILDING: _____ B. WING _____	09/01/2023

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0 680	Continued From page 30 - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. - an EP training and testing program	0 680		

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0 680	Continued From page 31 On September 1, 2023, at 3:30 p.m., the surveyor reviewed the missing EPP policies and procedures with LALD-A. LALD-A stated she was not aware the licensee's EPP was not fully developed. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 2, 2023, indicated the licensee's emergency preparedness would include all the required elements of appendix Z. The plan would be based on the licensee's risk assessment, utilizing an all-hazards approach and would include the following key elements: -Risk assessment and planning; -Policies and Procedures -A communication plan; and -Staff training and exercises and drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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0 780	Continued From page 32 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in each sleeping room and outside in immediate vicinity of the sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 30, 2023, at approximately 11:30 p.m. with maintenance (M)-H it was observed that smoke alarms were not interconnected in resident room 3 and outside the sleeping room in the apartment on the north end of building 3040. Smoke alarms are required to	0 780		

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0 780	Continued From page 33 be installed in sleeping rooms and outside in the immediate vicinity of the sleeping rooms and be interconnected. The activation of one alarm is required to activate all alarms throughout the building. This deficient finding was visually verified by M-H at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide portable fire extinguishers that were readily accessible and had no more than 75-foot travel distance within the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 34 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 residents). Findings: On a facility tour on August 30, 2023, at approximately 11:30 a.m. with maintenance (M)-H it was observed that the required accessible and available fire extinguisher was located in a closet and was not readily visible and available in building 3040, 3042 and 3044. Fire extinguishers are required to be readily visible and available for use by occupants of the building or provided with signs identifying the location. This deficient finding was visually verified by M-H at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 35 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include: During a facility tour and review of records provided on August 30, 2023, at approximately 12:00 p.m. with maintenance (M)-H it was observed the last required fire alarms system inspection and service was completed on June 14, 2021, for buildings 3040, 3042 and 3044. The fire alarm system requires annual inspection and service. It was also observed the exit sign was not illuminated and did not illuminate with activation of the test button in the corridor above resident room #6 in building 3040. Exit signs are required to be illuminated at all times in order to identify exits for egress in the event of an emergency or loss of power. It was also observed a light bulb in the bathroom was burnt out and a door handle was missing on the closet in the living room of resident room #5 in building 3040.	0 800		

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0 800	Continued From page 36 It was observed the last required fire sprinkler system inspection and service was completed on June 7, 2021, for buildings 3040, 3042 and 3044. The fire sprinkler system requires annual inspection and service. It was also observed that a hose bib on the hot water heat boiler system in the mechanical room of building 3040 was leaking on the floor. Hot water heating boilers systems are required to be maintained free of leaks that cause water damage to the structure. It was observed the electrical panel in the closet on the north end of the corridor in building 3042 was blocked with storage material. The space in front of electrical power panels is required to be maintained clear in order to provide access to the panel for service or in the event of an emergency. It was observed that there was a water leak on the backflow preventer in the mechanical room of building 3044. Facility water pipe systems are required to be maintained free of leaks that cause water damage to the building structure. It was observed the exit light in the apartment on the north end of building 3044 did not operate upon activation of the test button. Emergency lighting is required to be maintained to provide lighting for egress in the event of an emergency. These deficient conditions were visually verified by M-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 37	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the	0 810		

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0 810	Continued From page 38 licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on August 30, 2023, at approximately 10:15 a.m. of documents provided by maintenance (M)-H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the facility did not provide a fire safety and evacuation floor plan with location and number of resident rooms in buildings 3040, 3042 and 3044. A fire safety and evacuation floor plan map is required to be in a posted in a visible location for use by all occupants of the facility for evacuation in the event of an emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures necessary for residents during a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan	0 810		

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0 810	Continued From page 39 did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs of each resident for movement or evacuation. Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Employee training on the fire safety and evacuation plan is required to be conducted and documented separately from fire evacuation drills. Record review of the available documentation indicated the fire safety and evacuation plan was not readily available at all times in buildings 3044 and 3040. The fire safety and evacuation plan was only readily available in building 3042. The fire safety and evacuation floor plan is required to be available at all times within all three buildings. Record review of the available documentation indicated that the licensee did not offer training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Written documentation of training provided to residents in regard to actions required for evacuation is required once a year. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. At the time of review documentation indicated one drill was conducted in building 3040 in April 2023 and one drill was conducted in building 3042 in January 2023. Drills are required to be conducted and	0 810		

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0 810	Continued From page 40 documented for all three buildings separatly as the procedures are different. All deficiencies were verified by M-H during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 820		

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0 820	Continued From page 41 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 30, 2023, at approximately 11:30 a.m. with maintenance (M)-H, it was observed the marked exterior exit doors at the end of the corridors in buildings 3042 and 3044 were provided with magnetic locking devices. During the tour M-H indicated it was unclear if the marked exterior exit door locks were fail safe so that activation of a fire alarm system, fire sprinkler system or loss of power releases the door lock for the purpose of exiting in the event of an emergency. It was also stated by M-H the magnetic locks are not activated at this time. Special magnetic locking devices installed on exit doors are required to fail safe so that activation of the fire alarm system, fire sprinkler system or loss of power releases the lock to the open position. This deficient condition was verified by M-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910		

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0 910	Continued From page 42 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R4, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Lease Agreement, and Housing Agreement were signed by R4's legal representative on June 6, 2023. R4's Lease Agreement, and Housing Agreement were signed by R4's legal representative on April 5, 2022. R6's Lease Agreement, and Housing Agreement were signed by R6's legal representative on February 8, 2022. R1, R4, and R6's Lease Agreement and Housing Agreement lacked the following required content: - the HFID number (provider identification	0 910		

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0 910	Continued From page 43 number). On September 1, 2023, at 9:35 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by R1, R4, and R6's representatives and reviewed by the surveyor, lacked the above noted items. LALD-A stated all residents receiving services under the licensee's Assisted Living with Dementia Care license received the same agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	Continued From page 44 unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R4, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Lease Agreement, and Housing Agreement were signed by R1's legal representative on June 6, 2023. R4's Lease Agreement, and Housing Agreement were signed by R4's legal representative on April 5, 2022. R6's Lease Agreement, and Housing Agreement were signed by R6's legal representative on February 8, 2022. R1, R4, and R6's Lease Agreement and Housing Agreement lacked the following required content: -Contact information for ombudsman for Mental Health and Developmental Disabilities; and -Resident's right to obtain services from an unaffiliated service provider. On September 1, 2023, at 9:35 a.m., licensed	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 930	Continued From page 45 assisted living director (LALD)-A stated the licensee contracts signed by R1, R4, and R6's representatives and reviewed by the surveyor, lacked the above noted items. LALD-A stated all residents receiving services under the licensee's Assisted Living with Dementia Care license received the same agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;	0 940		

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0 940	Continued From page 46 (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R4, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Lease Agreement, and Housing Agreement were signed by R1's legal representative on June 6, 2023. R4's Lease Agreement, and Housing Agreement were signed by R4's legal representative on April 5, 2022. R6's Lease Agreement, and Housing Agreement	0 940		

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0 940	Continued From page 47 were signed by R6's legal representative on February 8, 2022. R1, R4, and R6's Lease Agreement and Housing Agreement lacked the following required content: -Whether there is a limit on the number of people at the ALF (Assisted Living Facility) who can receive customized living services or housing support, if so the limit must be provided; -Whether the ALF requires the resident private pay for a period of time, and the length of time required; -Contract information to obtain long-term care consulting services; and -The Toll-Free phone number for MAARC (Minnesota Adult Abuse Reporting Center). On September 1, 2023, at 9:35 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by R1, R4, and R6's representatives and reviewed by the surveyor, lacked the above noted items. LALD-A stated all residents receiving services under the licensee's Assisted Living with Dementia Care license received the same agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950		

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0 950	Continued From page 48 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R4, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 950		

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0 950	Continued From page 49 The findings include: R1's Lease Agreement, and Housing Agreement were signed by R1's legal representative on June 6, 2023. R4's Lease Agreement, and Housing Agreement were signed by R4's legal representative on April 5, 2022. R6's Lease Agreement, and Housing Agreement were signed by R6's legal representative on February 8, 2022. R1, R4, and R6's Lease Agreement and Housing Agreement lacked the following required content: -The right to name a designated representative with the statutory language. On September 1, 2023, at 9:35 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by R1, R4, and R6's representatives and reviewed by the surveyor, lacked the above noted items. LALD-A stated all residents receiving services under the licensee's Assisted Living with Dementia Care license received the same agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 50 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 51 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 11:11 a.m., during entrance conference with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C. LALD-A stated the licensee did not provide the resident and or resident's representative a written notice when admitted to the hospital or notify the OOLTC when resident was hospitalized for four days or longer. LALD-A stated she was unaware of the requirements. The licensee's Admission/Hospital/Discharge/Hospice Admission Roster undated, indicated R5 was admitted to the hospital August 22, 2023, and did not list a readmission date.	01060		

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01060	Continued From page 52 R5's diagnoses included mild cognitive impairment, history of a cardiovascular accident (stroke), and hypertension (high blood pressure). R5's Service Plan dated November 17, 2022, indicated R5 received the following services: medication management, safety checks, dressing, grooming, bathing, toileting, transferring, housekeeping and laundry. R5's Progress Note dated August 22, 2023, indicated R5 had a fall from his wheelchair at approximately 1:55 p.m., and was transported to the emergency room for evaluation. R5's Fall Incident Report dated August 22, 2023, indicated staff was escorting R5 to his room in his wheelchair, R5 put his feet down and R5 fell forward out of the wheelchair and onto the floor. R5 was transported to the emergency room for evaluation. R5's Minnesota Adult Abuse Reporting Center report filed August 23, 2023, at 12:42 p.m., by LALD-A indicated R5 had a fall from his wheelchair, was sent to the emergency room and diagnosed with a fractured nose and a C2 fracture (a break in the second vertebra in the neck) and was admitted to the hospital. R5's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date	01060		

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01060	Continued From page 53 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R5's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. The licensee's Emergency Relocation policy dated July 26, 2023, indicated in the event of an emergency relocation, the licensee would provide a written notice that contains, at a minimum: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider; and contact information for the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 54 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living with dementia care license for four of six employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-G, ULP-H, cook (C)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-C LPN-C was hired on August 8, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey, the surveyor observed LPN-C provide assisted living services.	01290		

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01290	Continued From page 55 LPN-C's employee record contained a background study affiliated with another license owned by the same licensee, dated September 6, 2011. LPN-C's employee record lacked evidence the licensee affiliated a background study with their license. ULP-G ULP-G was hired on June 22, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:16 a.m. the surveyor observed ULP-G administering R1's scheduled morning medications, check R1's blood glucose (sugar) with the Libre device (continuous blood glucose monitoring device), and administer R1's insulin. ULP-G's employee record contained a background study affiliated with another license owned by the same licensee, dated June 6, 2019. ULP-G's employee record lacked evidence the licensee affiliated a background study for their license. ULP-H ULP-H was hired on October 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H assist R6 with morning cares and administering R6's scheduled morning medications. ULP-H's employee record contained a background study affiliated with another license	01290		

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01290	Continued From page 56 owned by the same licensee, dated October 10, 2017. ULP-G's employee record lacked evidence the licensee affiliated a background study for their license. C-I C-I was hired on May 7, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated C-I cooked meals for the residents, and other assigned tasks as needed. C-I's employee record contained a background study affiliated with another license owned by the same licensee, dated May 7, 2019. C-I's employee record lacked evidence the licensee affiliated a background study for their license. On September 1, 2023, at 10:00 a.m., the surveyor and LALD-A checked the employee's background study in Net Study 2.0. LPN-C, ULP-G, ULP-H, and C-I, were not listed as having a background study affiliated with the licensee's license. LALD-A stated the back ground studies in LPN-C, ULP-G, ULP-H, and C-I's employee records were affiliated with the licensee's comprehensive home care license that was no long active. The licensee's Background Study policy dated July 30, 2023, indicated all employees will have a background study to ensure that the individual is authorized by the Minnesota Department of Health to provide direct contact and/or access to vulnerable adults.	01290		

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01290	Continued From page 57 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (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; (12) awareness of confidentiality and privacy;	01370		

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	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
01370	Continued From page 58 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel (ULP)-E, ULP-G, ULP-H) received the required training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on July 13, 2023, to provide assisted living services. R1's August 2023, medication administration record (MAR) indicated ULP-E administered medications R1's 8:00 a.m. medications on August 2, 2023. ULP-G ULP-G was hired on June 22, 2018, under the comprehensive home care license and began	01370		

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01370	Continued From page 59 providing assisted living services on August 1, 2021. On August 30, 2023, at 7:16 a.m. the surveyor observed ULP-G administering R1's scheduled morning medications, check R1's blood glucose (sugar) with the Libre device (continuous blood glucose monitoring device), and administer R1's insulin. ULP-H ULP-H was hired on October 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H assist R6 with morning cares and administering R6's scheduled morning medications. ULP-E, ULP-G, and ULP-H's employee record lacked evidence of training in the following areas: -training on fall prevention; -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. On September 1, 2023, at 10:15 a.m. licensed assisted living director (LALD)-A stated ULP-E, ULP-G, and ULP-H's employee records lacked evidence ULP-E, ULP-G and ULP-H had completed the training as indicated above. The licensee's Training and Competency Evaluations policy dated August 2, 2023, indicated training and competency evaluations for all ULP's shall include; -training on fall prevention;	01370		

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01370	Continued From page 60 -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 61 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes including all required content for four of five employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-E, ULP-G. ULP-H). 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	01470		

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01470	Continued From page 62 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-C LPN-C started employment on August 8, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey, the surveyor observed LPN-C provide assisted living services. ULP-E ULP-E was hired on July 13, 2023, to provide assisted living services. R1's August 2023, medication administration record (MAR) indicated ULP-E administered R1's 8:00 a.m. medications on August 2, 2023. ULP-G ULP-G was hired on June 22, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:16 a.m. the surveyor observed ULP-G administering R1's scheduled morning medications, check R1's blood glucose (sugar) with the Libre device (continuous blood glucose monitoring device), and administer R1's insulin.	01470		

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01470	Continued From page 63 ULP-H ULP-H was hired on October 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H assist R6 with morning cares and administering R6's scheduled morning medications. LPN-C, ULP-E, ULP-G, ULP-H,'s employee record lacked evidence LPN-C, ULP-E, ULP-G and ULP-H had completed the following orientation to assisted living topics: -an overview of this chapter (144G); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -a review of the types of assisted living services the employee will be providing and the facilities category of licensure. On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated LPN-C, ULP-E, ULP-G and ULP-H, had not completed the orientation to assisted living topics as indicated above. The licensee's Orientation of Staff and Supervisors and Content dated August 2, 2023, indicated the orientation must contain the following topics: -an overview of this chapter (144G); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 64 and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -a review of the types of assisted living services the employee will be providing and the facilities category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 65 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all required annual training content for each 12 months of employment for four of four employees (clinical nurse supervisor(CNS)-B,	01500		

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01500	Continued From page 66 licensed practical nurse(LPN)-C, unlicensed personnel(ULP)-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-B CNS-B was hired on December 7, 2021, to provide supervision and direct care services under the licensee's Assisted Living with Dementia Care license. Throughout the survey, the surveyor observed CNS-B supervise unlicensed personnel (ULP) and provide direct care services to residents. LPN-C LPN-C started employment on August 8, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey, the surveyor observed LPN-C provide assisted living services. ULP-G ULP-G was hired on June 22, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01500		

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01500	Continued From page 67 On August 30, 2023, at 7:16 a.m. the surveyor observed ULP-G administering R1's scheduled morning medications, check R1's blood glucose (sugar) with the Libre device (continuous blood glucose monitoring device), and administer R1's insulin. ULP-H ULP-H was hired on October 2, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H assist R6 with morning cares and administering R6's scheduled morning medications. CNS-B, LPN-C, ULP-G, ULP-H,'s employee record lacked evidence of completion of the following annual training topics for 2022: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging	01500		

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01500	Continued From page 68 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated CNS-B, LPN-C, ULP-G, and ULP-H had not completed the above identified training for the year 2022. The licensee's Annual Training policy dated July 30, 2023, indicated annual training is described as training that is required by [facility name] and the state of Minnesota on an annual bases for continued employment at [facility name]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 69 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure five of five employees (clinical nurse supervisor (CNS)-B, licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-E, ULP-G, ULP-H) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-B CNS-B was hired on December 7, 2021, to provide supervision and direct care services under the licensee's Assisted Living with Dementia Care license. Throughout the survey, the surveyor observed	01540		

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01540	Continued From page 70 CNS-B supervise unlicensed personnel (ULP) and provide direct care services to residents. LPN-C LPN-C started employment on August 8, 2011, under the comprehensive home care license and began providing assisted living services on August 1, 2021. Throughout the survey, the surveyor observed LPN-C provide assisted living services. ULP-E ULP-E was hired on July 13, 2023, to provide assisted living services. R1's August 2023, medication administration record (MAR) indicated ULP-E administered R1's 8:00 a.m. medications on August 2, 2023. ULP-E's employee record lacked evidence ULP-E had completed eight (8) hours of dementia training within 80 hours of the employment start date. ULP-G ULP-G was hired on June 22, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:16 a.m. the surveyor observed ULP-G administering R1's scheduled morning medications, check R1's blood glucose (sugar) with the Libre device (continuous blood glucose monitoring device), and administer R1's insulin. ULP-H ULP-H was hired on October 2, 2017, under the	01540		

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01540	Continued From page 71 comprehensive home care license and began providing assisted living services on August 1, 2021. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H assist R6 with morning cares and administering R6's scheduled morning medications. CNS-B, LPN-C, ULP-G and ULP-H's employee records indicated CNS-B, LPN-C, ULP-G and ULP-H, had not completed the required two (2) hours of dementia training for 2022. On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated ULP-E had worked 80 hours and ULP-E's employee record lacked evidence ULP-E had completed eight (8) hours of dementia training. LALD-A also stated CNS-B, LPN-C, ULP-G and ULP-H had not completed the required two (2) hours of dementia training for 2022. The licensee's Orientation and Training Policy, dated August 2023, indicated direct care staff will complete eight (8) hours of dementia training within 80 hours of your first day of employment and two (2) hours of training required on topics related to dementia care for each 12 months of empowerment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	01550		

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01550	Continued From page 72 (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (cook(C)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 30, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided services to residents with diagnoses of related disorders to dementia. C-I was hired on May 7, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01550		

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01550	Continued From page 73 On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated C-I cooked meals for the residents, and other assigned tasks as needed. C-I's employee record lacked evidence C-I completed at least two (2) hours of training on topics related to dementia care for each 12 months of employment thereafter. On September 1, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated C-I had not completed two (2) hours of dementia training for 2022. The licensee's Orientation and Training policy dated August 2023, indicated non-direct care staff must complete two (2) hours of training on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 74 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) reassessed one of one resident (R1) with repeated falls and the use of sensor motion alarms and for one of one resident (R6) who had incidents of elopement. In addition, the licensee failed to ensure the RN completed a comprehensive reassessment using the uniform assessment tool on day 90 for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01620		

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01620	Continued From page 75 FALLS/SENSOR ALARMS R1 R1's diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dementia. On August 30, 2023, at 6:43 a.m., the surveyor observed unlicensed personnel (ULP)-E assist with R1's morning cares. During R1's morning cares, the surveyor observed a sensor alarm on the floor next to R1's bed and an alarm on the right arm of R1's wheelchair. ULP-E stated R1 attempted to transfer himself into bed and has had a few falls so the alarms were put in place to alert staff when R1 was transferring. R1's Service Plan dated June 8, 2023, indicated R1 required assistance with dressing, grooming, toileting, bathing, transferring, medication management, blood glucose monitoring, housekeeping and laundry. R1's Fall Incident Reports indicated the following: -June 16, 2023, at 8:00 a.m., R1 was found on the floor, on his stomach, wrapped in blanket after attempting to self-transfer into his bed. R1's left thumb was swollen and R1 complained of pain to his left thumb. R1 was sent into the emergency department for evaluation and was diagnosed with a fracture to his left thumb. Interventions included educating R1 on the importance of using the call light for assistance. No new fall interventions were implemented. -July 28, 2023, at 3:30 p.m., R1 had an unwitnessed fall and wad found on the floor after R1 attempted to self-transfer. Neurological checks were initiated and R1 was educated to use his call light. No new fall interventions were implemented.	01620		

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01620	Continued From page 76 -August 20, 2023, R1 was found lying on his stomach in his room. R1 stated he was trying to get into his bed. R1 obtained 1 ½ inch laceration below his left knee. R1 was educated on using staff for assistance with transferring. No new fall interventions were implemented. R1's admission assessment dated June 6, 2023, indicated a fall assessment score of eight (8), which indicted a score four (4) or more was considered at risk for falls. R1's 14-day assessment dated June 16, 2023, did not include an assessment of falls or the use of sensor alarms, and indicted R1 had no changes. R1's Vulnerable Adult Plan and Intervention dated June 2023, indicated R1 did not have a decreased safety awareness. R1's Care Plan dated June 6, 2023, indicated R1 was at risk for falls and R1's fall interventions included: -call light in reach at all times; -staff would monitor for decline in physical function and report to nursing; and -R1 would use the call light to request assistance with transferring and toileting. R1's record lacked evidence the RN reassessed R1 after each fall for causal factors, the use of a sensor alarm or a developed fall prevention plan. On September 1, 2023, at 12:14 p.m., clinical nurse supervisor (CNS)-B reviewed R1's fall incident reports and stated after each fall R1 was educated on using his call pendant for assistance with transfers. CNS-B stared after R1's falls, motion sensor alarms were implemented, which	01620		

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01620	Continued From page 77 had not been identified in R1's assessments, care plan or identified on R1's fall incident reports. CNS-B stated motion sensors did not prevent falls; however, alerted staff when residents were moving. CNS-B stated fall interventions had not implemented after each of R1's falls. ELOPEMENT R6 R6's diagnoses included dementia. R6's Service Plan dated February 8, 2022, indicated R6 required assistance with dressing, grooming, bathing, medications management, TED stockings, safety checks, housekeeping and laundry. R6's Uniform Assessment Form dated April 7, 2023, indicated R6 scored a zero on the elopement assessment which indicated a score of 0-3 was a low risk for elopement. R6's Vulnerable Adult Assessment dated April 7, 2023, indicted R6 did not wander or had a history of elopement. R6's Progress Notes indicated on July 30, 2023, at 8:00 a.m., staff noticed R6 was not in her room, other staff were alerted and a search inside and outside of the buildings was initiated. LALD-A was notified, and LALD-A notified the police. At 8:20 a.m., R6 was brought back to the facility by the police. House 1's Weekly Update dated August 11, 2023, indicated R6 had been exit seeking more often and make sure the electric doorstop is in place at the front door. The licensee was working with the family and primary care provider to help R6 with anxiety and depression symptoms.	01620		

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01620	Continued From page 78 R6's Minnesota Adult Abuse Reporting Center report was filed August 30, 2023, at 11:55 a.m., by LALD-A after the surveyor requested all MAARC reports for the last six months during the entrance conference on August 29, 2023, at 11:15 a.m. R6's MAARC report indicated on July 30, 2023, at 8:00 a.m., LALD-A received a call at 8:05 a.m., reporting staff was unable to locate R6 in the building. Staff searched for R6 on the premises and the surrounding area by car. LALD-A notified the police and LALD-D was informed by the dispatcher a neighbor reported R6 was observed standing outside and to the north of the facility. The neighbor had called the police and the police brought R6 to her previous address. 911 dispatch notified the police the licensee reported R6 was a missing and the police brought R6 back to the facility at 8:20 a.m. R6's Care Plan dated April 20, 2023, had not been updated to include elopement interventions. R6's record lacked evidence R6 was reassessed to determine R6's elopement risk level and the development and implementation of interventions. On September 1, 2023, at 12:14 p.m., CNS-B stated a change in condition assessment had not been completed for R6 and should have been reassessed for R6's change in behaviors including increase anxiety, weepiness, wandering throughout the building, exit seeking, and elopement incident. The licensee's Elopement/Missing Resident policy dated July 5, 2023, indicted upon locating the resident, a nurse would perform a physical assessment of the resident and complete the appropriate documentation.	01620		

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01620	Continued From page 79 90 DAY ASSESSMENT R4 R4's diagnoses included atrial/flutter (abnormal heart rhythm), and dementia. R4's Service Plan dated April 5, 2022, indicated R4 received assistance with medication administration, bathing, weekly shower, eats meals in room, laundry, and housekeeping. On August 31, 2023, at 1:00 p.m., the surveyor observed R4 eating lunch in her room. R4's record contained one Uniform Assessment Tool dated April 22, 2023. R4's subsequent 90 day assessment would have been due on July 21, 2023. On September 1, 2023, at 9:35 a.m., the surveyor requested any assessments that were completed after April 22, 2023. The surveyor was provided R4's Quality Assurance Documentation dated January 23, 2023, February 2, 2023, and March 13, 2023. On September 1, 2023, at 9:35 a.m., licensed assisted living director (LALD)-A stated the Quality Assurance Documentation is to be completed monthly for each resident. LALD-A stated the Quality Assurance documentation does not include all the required components of the Uniform Assessment Tool. CNS-B stated the last 90-day assessment using the Uniform Assessment Tool was completed on April 22, 2023. The licensee's Assessment Schedule policy dated August 9, 2023, indicated ongoing resident reassessments and monitoring are completed as	01620		

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01620	Continued From page 80 needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. The licensee's Assessments, Reviews and Monitoring policy dated August 9, 2023, indicated initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 81 authority to sign for the resident in an emergency; and (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident's (R4) service plan included all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included atrial/flutter (abnormal heart rhythm), and dementia. R4's service plan dated April 5, 2022, indicated R4 received assistance with medication administration, bathing, weekly shower, eats meals in room, laundry, and housekeeping. R4's service plan dated April 5, 2022, did not include the following required content: -fees. On September 1, 2023, at 9:35 a.m. licensed assisted living director (LALD)-A stated R4's	01650		

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01650	Continued From page 82 service plan dated did not include the fees because the resident was on elderly waiver. The licensee's Service Plan policy dated July 5, 2023, indicated the service plan must include the fees for service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three unlicensed personnel (ULP)-E received training by the registered nurse (RN) and demonstrated competency to the RN prior to administering medications to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 83 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on July 13, 2023, to provide assisted living services. R1's August 2023, medication administration record (MAR) indicated ULP-E administered R1's 8:00 a.m. medications on August 2, 2023. R9's August 2023 MAR indicated ULP-E administered R9's 8:00 a.m. medications on August 2, 2023. The PRN (as necessary) Medication and Supplies Log for August 2023, indicated ULP-E administered acetaminophen for pain to R1 on August 2, 2023. ULP-E's Orientation Check-off Sheet indicated ULP-E demonstrated competency on medication administration to the RN on August 4, 2023. On September 1, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated ULP-E demonstrated competency of medication administration to the RN on August 4, 2023. The licensee's Delegation of Assisted Living Services policy dated August 9, 2023, indicated when the RN delegates tasks to ULP, that person well ensure that prior to the delegation the ULP is trained in the proper methods to perform the	01750		

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01750	Continued From page 84 tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedure and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the effectiveness of PRN (as necessary) medications were documented for two of two residents (R1, R4) and failed to ensure medications were administered as ordered for two of two residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 85 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: PRN MEDICATIONS R1 R1's prescriber orders dated July 5, 2023, included the following orders: -hydrocodone-acetaminophen (Norco) 5/325 milligrams (mg) (opioid pain reliever) one tablet every six hours as needed. R1's July 2023, medication administration record (MAR) indicated the following prescribed PRN medications: -acetaminophen 600 mg one tablet every four to six hours as needed for pain; and -Norco 5/325 mg one tablet every six hours as needed for pain. R1's July 2023, MAR indicated the effectiveness of acetaminophen 650 mg was not documented three of three times the medication was administered, and the effectiveness of Norco 5/325 mg was not documented four of four times the medication was administered. R4 R4's prescriber's orders dated July 13, 2023, included Metoprolol Tartrate (treats high blood pressure) 25 mg one tablet by mouth PRN for heart rate above 110. Ok to take two (2) tablets in	01760		

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	25455	A. BUILDING: _____ B. WING _____	09/01/2023

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01760	Continued From page 86 24 hours and acetaminophen 650 mg one tablet every 4 to 6 hours PRN for pain/temperature. R4's July 2023, MAR indicated the following: -The effectiveness of Metoprolol Tartrate 25 mg was not documented four of four times the medication was administered. -The effectiveness of acetaminophen 650 mg was not documented eight of eight times the medication was administered. R4's Progress Notes for July 2023, did not address the effectiveness of the PRN medications administered to R4. On September 1, 2023, at 8:22 a.m., clinical nurse supervisor (CNS)-B stated staff should be documenting the effectiveness of all PRN medications administered on the back of the resident's MAR or in a progress note. CNS-B stated R1's PRN medications administered were not followed up as indicated above. On September 1, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A state the effectiveness of PRN medications was to be documented on the back of the resident's MAR or the progress notes. LALD-A stated the effectiveness of R4's PRN medications were not documented as indicated above. MEDICATIONS AS ORDERED R1 R1's prescriber orders dated September 13, 2023, included the following: -Symbicort inhaler (used to treat wheezing and shortness of breath) two puffs twice a day and to rinse mouth after use; and -Humalog Kwikpen (short-acting) insulin 100 units	01760		

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01760	Continued From page 87 (u)/milliliters (ml) inject four units before supper as needed for a blood glucose greater than 300. R1's August 2023 MAR directed to administer Humalog (fast-acting insulin) four units for blood sugar above 300 for dinner time as needed. R4's August MAR did not include Symbicort inhaler. R1's August 2023 MAR indicated at 8:45 p.m., R1 received four units of Humalog for a blood sugar of 294 per wife's request. On August 30, 2023, 7:16 a.m., the surveyor observed ULP-G prepare and administered R1's medications and inhaler. ULP-G shook R1's inhaler, placed the inhaler mouth piece into R1's mouth, instructed R1 to take a breath in while administering one puff of the medication. ULP-G proceed to administer R1's eye drops and pills. ULP-G did not administer R1's second puff of the inhaler or instruct R1 to rinse his mouth after the first puff of the inhaler. ULP-G exited R1's room and documented the administration of R1's medications in R1's MAR. ULP-G stated she did not administer two puffs of the inhaler or have R1 rinse his mouth after use. ULP-G confirmed R1's August MAR did not include an order for the administration of Symbicort inhaler. On September 1, 2023, at 8:22 a.m., CNS-B stated R1's August 2023, MAR directed to administer four units of Humalog insulin for blood sugars above 300. CNS-B stated staff should not have administered PRN Humalog insulin for R1's blood sugar of 294 and would be considered a medication order. CNS-B stated R1's August MAR did not include an order for R1's Symbicort inhaler and would have to consult with licensed practical nurse (LPN)-C who was responsible for resident medications.	01760		

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01760	Continued From page 88 R4 R4's prescriber's orders dated July 13, 2023, start Eliquis 2.5 mg (anticoagulation) and stop aspiring 81 mg. R4's July 2023, MAR indicated aspirin 81 mg continued to be administer on July 14 to 31, 2023. R4's July 2023 MAR indicated Eliquis 2.5 mg at 8:00 a.m., but it could not be determined what date the Eliquis was started. On September 1, 2023, at 10:30 a.m., LALD-A and LPN-C both stated R4's July 2023 MAR did not indicate when the Eliquis was started and when the aspirin was stopped. The licensee's PRN Medication policy dated August 9, 2023, indicated staff will also document the effects of the PRN medication in the resident's progress notes, one the back of the MARS, and the PRN flow sheet. The licensee's Medication and Treatment Orders-Implementing policy dated August 9, 2023, indicated medications would be administered as ordered and licensed staff will monitor the implementation of the orders monthly and as need. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770		

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01770	Continued From page 89 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all required content for two of two residents (R1, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 29, 2023, at 11:11 a.m., licensed practical nurse (LPN)-C stated she sets up medication in medication planners (a plastic medication box with designated compartments for days at a time) weekly on Mondays. R1 R1's diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dementia. On August 29, 2023, at 1:34 p.m., the surveyor observed unlicensed personnel (ULP)-E prepare R1's scheduled 2:00 p.m., medications by taking	01770		

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01770	Continued From page 90 the pill from a prefilled medication planner and place into a paper medication cup and administer to R1. R1's Service Plan dated June 8, 2023, indicated R1 received weekly medication set-up services. R1's Medication Management Plan Informed Consent dated June 8, 2023, indicated R1 received weekly medication set up by the licensed practical nurse in medication planners. R1's August 2023, Medication Administration Record (MAR) indicated LPN-C set up R1's medications on the following dates: August 7, 14 and 18, by LPN-C by LPN-C initials noted on those dates on R1's MAR. R1's record lacked documentation for medication setup at the time of setup to include the name of the medication, quantity of dose, times to be administered, and route of administration being set up. R8 R8's diagnoses included dementia. On August 30, 2023, at 7:45 a.m., the surveyor observed ULP-H prepare R8's morning medications by taking pills from a prefilled medication planner and placed into R8's pills onto a paper medication cup and administer to R8. R8's Service Plan dated November 8, 2021, indicated R8 received weekly medication set-up services. R8's Medication Management Plan Informed Consent form dated July 10, 2019, indicated R8 received weekly medication set up by the	01770		

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01770	Continued From page 91 licensed practical nurse in medication planners. R8's August 2023, MAR indicated LPN-C set up R8's oral medications on the following dates August 7, 14, 22, and 28 by LPN-C initials noted on those dates on R8's MAR. R8's record lacked documentation for medication setup at the time of setup to include the name of the medication, quantity of dose, times to be administered, and route of administration being set up. On September 1, 2023, at 1:10 p.m., LPN-C stated she does not document each medication set up and stated she initials on the bottom of the resident's MAR the date when she set up the medications for the week. LPN-C confirmed the medication set up documentation does not meet all required content. The licensee's Medication Set Up policy dated May 18, 2023, indicated medication set up was complete weekly by licensed staff; however, the policy did not indicate how the licensed staff should document each medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 92 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for four of four medication refrigerators. In addition, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for three of four refrigerators being used to store medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 10:15 a.m., the surveyor toured building one with unlicensed personnel (ULP)-D and observed prefilled insulin being stored in plastic pencil box in the door of the main unsecured refrigerator in the kitchen along with food items. ULP-D stated she was unable to find a thermometer in the refrigerator or recorded temperature logs. The following medications were observed being stored: -six (6) prefilled Lantus (long acting) insulin syringes for R8. On August 29, 2023, at 10:31 a.m., the surveyor	01880		

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01880	Continued From page 93 toured building two with ULP-D and observed prefilled insulin being stored in a plastic pencil box in the door of the main unsecured refrigerator in the kitchen on long with food items. ULP-D stated she was unable to find a thermometer in the refrigerator or recorded temperature logs. The following medications were observed being stored: -seven (7) prefilled Humalog (fast acting) insulin syringes for R11; -six (6) prefilled Lantus insulin syringes for R11; and -three (3) unopened Trulicity (non-insulin to treat high blood sugar) pens for R12. The surveyor and ULP-D observed the locked medication refrigerator in building two and ULP-D stated only the nurses had keys to the medication refrigerator. On August 29, 2023, at 10:45 a.m., the surveyor toured building three with ULP-D and observed prefilled insulin syringes being stored in a plastic pencil box in the door of the main unsecured refrigerator in the kitchen along with food items. ULP-D stated she was unable to find a thermometer or recorded temperature logs. The following medications were observed being stored: -three (3) unopened Trulicity pens for R1; -six (6) prefilled Novolog insulin syringes for R1; -six (6) prefilled Toujeo (long acting) insulin syringes for R1; and -two (2) prefilled insulin syringes in a black pencil box without name of insulin labeled (PRN) for R1. On August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B stated the licensee provided medication storage in each of the three buildings including medications requiring	01880		

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01880	Continued From page 94 refrigeration. LPN-C stated there was one locked medication refrigerator in building 2 where unopened insulin were being stored and was locked. LPN-C stated she prefilled insulin syringes and kept the insulin in the main refrigerator in each of the house for the week for staff to later administer. The surveyor requested three months of refrigerator temperature logs for review. On August 30, 2023, at 10:19 p.m., clinical nurse supervisor (CNS)-B stated she was not sure if staff were monitoring refrigerator temperatures for storage of medications. The surveyor made second request for copies of the recorded refrigerator temperatures. On September 1, 2023, at 11:45 a.m., the surveyor made a third request for the refrigerator temperature logs. On September 1, 2023, at 12:35 p.m., LPN-C stated she fills the insulin every Monday and stores the prefilled insulin syringes in the main refrigerators in each of the houses which were not secured. LPN-C stated she was unaware medications being stored in the main refrigerators needed to be securely stored. On September 1, 2023, at 1:06 p.m., LALD-A provided the surveyor with the licensee's Medication Refrigerator Temperature logs with one recorded temperature of 36 degrees Fahrenheit (F) dated September 1, 2023, with no other information or directions on the log indicating appropriate temperature range, who or what to do if the temperature was out of range and what refrigerator was being monitored. LALD-A stated she was unable to find any temperature logs for the refrigerators and stated	01880		

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01880	Continued From page 95 they just started monitoring temperatures today. LALD-A stated the temperature log provided was from the locked medication refrigerator in building two and had not thought about monitoring the other refrigerators where medications were being stored. On September 1, 2023, at 2:51 p.m., the surveyor observed the secured medication refrigerator with LPN-C and verified the current internal thermometer was 36 degrees F and observed the following medications: -one (1) opened vial of Lantus 100 units (u)/milliliters (ml) for R1; and -seven (unopened) Humalog Kwik 100 u/ml insulin pens for R1. The manufacturer's instructions for Lantus insulin dated December 2020, indicated to store unused Lantus vials in the refrigerator between 36-46 degrees F and do not freeze. Unused Lantus should be discarded 28 days after opened. The manufacturer's instructions for Humalog KwikPen insulin dated November 2019, indicated unopened Humalog to store in the refrigerator between 36-46 degrees F and Humalog prefilled pens should be stored at room temperature and used within 28 days after opened. The manufacturer's instructions for Toujeo insulin dated April 2023, indicated to store unopened insulin pens in the refrigerator between 36-46 degrees F. Opened Toujeo insulin pens should not be put back in the refrigerator and should be stored at room temperature. The manufacturer's instructions for Trulicity injection pen dated September 2018, indicated to store unopened Trulicity in the refrigerator at	01880		

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01880	Continued From page 96 36-46 degrees F and do not freeze. The manufacturer's instructions for Novolog insulin pen dated October 2021, indicated to store unopened Novolog in the refrigerator at 36-46 degrees F and do not freeze. The licensee's Storage of Medications policy, dated May 17, 2023, indicated stored medications were to be kept secured. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications and failed to monitor for expired medications for three of three medication storage carts. 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	01890		

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01890	Continued From page 97 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: BUILDING TWO MEDICATION CART On August 29, 2023, at 2:41 p.m., the surveyor observed the medication cart in building two with unlicensed personnel (ULP)-F. ULP-F confirmed the following: -R2's opened bottle of Timolol eye drop (used to tread high pressure in the eye) lacked the date the eye drop had been opened and when the eye drop would expire. -R2's nystatin powder expired June 6, 2022. -R13's Albuterol HFA inhaler expired June 21, 2022. -a bottle of artificial tears lacked an original prescription label with information regarding the directions for use, medication dosage, resident's name, and the pharmacy in which it had been issued. -a bottle of Daily Relief Lactose lacked a prescription label and expired September 2021. BUILDING THREE MEDICATION CART On August 29, 2023, at 3:07 p.m., the surveyor observed the medication cart in building three with ULP-G. ULP-G confirmed the following: -R1's had two opened Symbicort inhalers which lacked the dates the inhalers were opened and when the inhalers would expire. -R13 had two opened bottles of Systane eye drops which lacked an original prescription label with information regarding the directions for use, medication dosage, resident's name, and the	01890		

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01890	Continued From page 98 pharmacy in which it had been issued. -one stock bottle of antacid expired June 2023. ULP-G stated she had not been instructed to write the opened and expiration dates on time sensitive medications to include eye drops, insulins, and inhalers and referred to the expiration date on the packaging. ULP-G removed the expired medications noted above from the medication cart to bring to the nurse. BUILDING ONE MEDICATION CART On August 29, 2023, at 3:21 p.m., the surveyor observed the medication cart in building one with ULP-K. ULP-K confirmed the following: -R8's nitroglycerin sublingual tablets 0.4 mg expired September 30, 2021. -a stock bottle of antacid tablets expired November 2022. -a stock bottle of Robafen 10/100 mg liquid cough suppressant expired November 2022. On September 1, 2023, at 12:35 p.m., licensed practical nurse (LPN)-C stated it was not their practice to write opened or expiration dates on insulins, eye drops or inhalers when opened. The manufacturer's instructions for Timolol eye drops dated January 2020, indicated to discard 28 days after first opening the bottle. The manufacturer's instructions for Symbicort dated December 2017, indicated to discard when the counter reaches zero or three months after the Symbicort is removed from its foil pouch, whichever comes first. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

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01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one	01940		

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01940	Continued From page 100 resident (R4) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents. R4's diagnoses included atrial/flutter (abnormal heart rhythm), and dementia. R4's prescriber orders dated August 15, 2023, included TED stockings (compression stockings) apply each morning and remove TED stockings at bedtime as tolerated. On August 31, 2023, at 1:00 p.m., the surveyor observed R4 sitting in her room wearing TED stockings. R4's service plan dated April 5, 2022, did not include a written statement pertaining to TED stockings. R4's Medication/Treatment/Therapy Management Plan dated April 5, 2022, did not include evidence of an individualized treatment or therapy management plan for TED stockings which included the following: - a statement of the type of services that would be	01940		

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01940	Continued From page 101 provided - documentation of specific resident instructions relating to the treatment or therapy administration - identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP), and - procedures for notifying the RN (registered nurse) or appropriate licensed health professional when a problem arises with treatments or therapy services. On September 1, 2023, at 9:30 a.m., LALD-A stated R4's service plan and medication/treatment/therapy Management Plan did not include TED stockings. The licensee's Medication and Treatment Orders policy dated April 4, 2022, indicated upon receipt of treatment orders appropriate changes will be made to the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960		

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01960	Continued From page 102 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included atrial/flutter (abnormal heart rhythm), and dementia. R4's prescriber orders dated August 15, 2023, included TED stockings (compression stockings) apply each morning and remove TED stockings at bedtime as tolerated. On August 31, 2023, at 1:00 p.m., the surveyor observed R4 sitting in her room wearing TED stockings. R4's service plan dated April 5, 2022, did not include a written statement pertaining to TED stockings. R4's Medication/Treatment/Therapy Management Plan dated April 5, 2022, did not	01960		

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01960	Continued From page 103 include evidence of an individualized treatment or therapy management plan for TED stockings. R4's record lacked documentation to indicate R4's TED stockings had been applied as ordered. On September 1, 2023, at 9:30 a.m., licensed practical nurse (LPN)-C stated the application of R4's TED stockings was not documented in R4's record. The licensee's Medication and Treatment policy dated July 28, 2023, indicated medications and treatment would be performed as ordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the	02040		

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02040	Continued From page 104 licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted August 30, 2023, at approximately 11:00 a.m. with maintenance (M)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around this specific property. This deficient condition was verified by M-H during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

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02140	Continued From page 105 (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (clinical nurse supervisor (CNS)-B), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. On August 29, 2023, at 11:11 a.m., during entrance conference, licensed assisted living director (LALD)-A named CNS-B as the responsible staff overseeing/providing staff training for dementia care.	02140		

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02140	Continued From page 106 On August 30, 2023, at 9:52 a.m., CNS-B stated she took a course by Care Providers and thought it should cover the required dementia training. The surveyor was provided a copy of CNS-B's Assisted Living Nurse Managers' and Managers and Directors' Educations Series completed April 14, 2022, and CNS-B stated that was the course she was referring to for her dementia care training. CNS-B stated the certificate provided did not indicate dementia care training was provided to meet the above requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents (R1, R2, R3) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	02310		

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02310	Continued From page 107 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). This resulted in an immediate correction order on August 30, 2023. The findings include: R1 R1's diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dementia. On August 29, 2023, at 1:34 p.m., the surveyor observed R1 had a standard bed with a consumer metal bed rail positioned on the right upper side of the bed. The base of the bed rail was not secured to the bed and was tucked between a piece of plywood placed over the bed frame and the box spring. R1's Service Plan dated June 8, 2023, indicated R1 required assistance with dressing, grooming, toileting, bathing, transferring, medication management, blood glucose monitoring, housekeeping and laundry. R1's Bed Side Rail and Enabler Utilization Assessment/Evaluation and Consent Form, dated June 6, 2023, indicated R1 required assistance getting in and out of bed and R1 had a decrease in safety awareness. R1's assessment indicated R1 had three (3)- ½ to ¼ sized bed rails with a gap measuring less than six (6) inches between the bed rail and the mattress and was secured under the mattress. R1's Plan of Care dated June 6, 2023, did not	02310		

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02310	Continued From page 108 indicate R1 required the use of a bed rail. R1's record lacked the following: -installation and use of the device according to manufacturer's guidelines; and -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. R2 R2's diagnoses included vascular dementia, autistic disorder, and hypertension (high blood pressure). On August 29, 2023, at 10:31 a.m., during a tour of house two (2) with unlicensed personnel (ULP)-D, the surveyor observed R2 had upper bilateral bed rails in the upright position, attached to a hospital bed. R2 was resting in a recliner chair in his room. R2's Service Plan dated February 16, 2023, indicated R2 required assistance with dressing, grooming, bathing, transfers, toileting, safety checks, ambulation, medication management, housekeeping and laundry. R2's Bed Side Rail and Enabler Utilization Assessment/Evaluation and Consent Form dated February 16, 2023, indicated R2 had a hospital bed with bilateral ½ side rails which were secured to the bed. The side rail gap measured less than six (6) inches between the side rail and the mattress. R2's Care Plan dated May 8, 2023, did not indicate R2 required the use of a bed rail. R2's record lacked a comprehensive assessment on the use of an assistive device to include actual	02310		

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02310	Continued From page 109 measurements of the entrapment zones and information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. R3 R3 diagnoses included late onset Alzheimer's disease and generalized muscle weakness. R3's Service Plan dated February 22, 2023, indicated R3 required cue assistance with dressing, grooming, bathing, and assistance with medication management, housekeeping and laundry. R3's Admission Assessment dated February 22, 2023, indicated R3 was independent in bed mobility and did not require any bed mobility devices. On August 29, 2023, at 10:30 a.m., CNS-B stated residents who had bed rails were provided a A Guide to Bed Safety pamphlet, dated April 2010, on the safety and explained the benefits and risks for the use of bed rails. CNS-B stated the registered nurse completes a bed rail assessments and measures between the bars of the bed rail and the space between the mattress and bed rail. CNS-B stated there was no documentation in the any of the resident records measurements of the entrapment zones. On August 29, 2023, at 11:05 a.m., CNS-B observed and verified R1's consumer bed rail was loose, had white tape around an area which appeared to have been missing hardware, did not appear it was properly installed and could be a safety concern. CNS-B stated R1's family installed the bed rail and CNS-B suggested R1's family secure the bed rail to the bed and verified it	02310		

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02310	Continued From page 110 had not been done. CNS-B stated she was aware of the of the piece of plywood under R1's mattress but was unaware of the current condition of R1's bed rail. CNS-B stated she does not check the Consumer Product Safety Commission (CSPC) website to ensure the consumer bed rails being used were not recalled. On August 30, 2023, at approximately 2:00 p.m., licensed assisted living director (LALD)-A was informed of the above information. LALD-A identified R3 of having bed rails and viewed R3's record to review R3's bed rail assessment. LALD-A confirmed R3's record indicated R3 did not have bed rails. The surveyor and clinical nurse supervisor (CNS)-B checked R3's room and observed R3 had a hospital bed with attached bed rails. RN-I stated when R3 was admitted, R3 had a twin bed without bed rails and since received a hospital bed with bed rails when she returned from a stay at a rehabilitation center following a hospitalization. RN-I reviewed R3's record and stated there was no documentation in R3's record when R3 received the hospital bed and would have to look in to it further. RN-I stated R3's record lacked a bed rail assessment with measurements and documentation an explanation of risk and benefits was provided. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated August 7, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain,	02310		

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02310	Continued From page 111 uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks): - The resident's preferences: - Installation and use according to manufacturer's guidelines: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Assisted Living Resources & Frequently Asked Questions (FAQs), last updated August 7, 2023, current recommendations for recall include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information	02310		

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02310	Continued From page 112 on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Side Rail policy dated August 9, 2023, indicated the licensee would ensure the side rail was safe, used consistent with manufacturer's directions, installed securely and maintained in good operating condition and be aware of "wobbly" side rails. The license would inform hospice providers and medical equipment suppliers that residents would only be permitted to use side rails that comply with 2006 FDA dimensional guidance to reduce entrapments. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was not removed as of survey exit on September 1, 2023.	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03000	Continued From page 113 unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by:	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03000	Continued From page 114 Based on observation, interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R6) who had incidents of elopement and for one of one resident (R1) who had a significant injury with a fall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 29, 2023, at 11:11 a.m., the evaluator licensed asked assisted living director (LALD)-A if the licensee had any elopements in the past six months. LALD-A stated a resident in house one recently left the premises and was brought back to the facility by the police. LALD-A stated she did not file a MAARC report and was unaware the elopement incident required a MAARC report. LALD-A stated the licensee initiated a resident search, the police were notified, and family was updated. The surveyor requested MAARC and incident reports for the last six months to review. R6 R6 was admitted February 8, 2022. R6's diagnoses included dementia. R6's Service Plan dated February 8, 2022,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03000	Continued From page 115 indicated R6 required assistance with dressing, grooming, bathing, medications management, TED (thromboembolic deterrent (compression) stockings, safety checks, housekeeping and laundry. R6's Progress Notes indicated on July 30, 2023, at 8:00 a.m., staff noticed R6 was not in her room, other staff were alerted and a search inside and outside of the buildings was initiated. LALD-A was notified, and LALD-A notified the police. At 8:20 a.m., R6 was brought back to the facility by the police. R6's Progress Note dated August 30, 2023, at a late entry indicted RN-J received a call from LALD-A and informed R6 had eloped from the facility and was brought back to the facility by the police. LALD-A directed RN-J to call and notify R6's daughter. R6's Minnesota Adult Abuse Reporting Center report was filed August 30, 2023, at 11:55 a.m., by LALD-A after the surveyor requested all MAARC reports for the last six months during the entrance conference on August 29, 2023, at 11:15 a.m. R6's MAARC report indicated on July 30, 2023, at 8:00 a.m., LALD-A received a call at 8:05 a.m., reporting staff was unable to locate R6 in the building. Staff searched for R6 on the premises and the surrounding area by car. LALD-A notified the police and LALD-D was informed by the dispatcher a neighbor reported R6 was observed standing outside and to the north of the facility. The neighbor had called the police and the police brought R6 to her previous address. 911 dispatch notified the police the licensee reported R6 was a missing and the police brought R6 back to the facility at 8:20 a.m.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03000	Continued From page 116 R1 R1 was admitted June 6, 2023. R1's diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dementia. R1's Service Plan dated June 8, 2023, indicated R1 required assistance with dressing, grooming, toileting, bathing, transferring, medication management, blood glucose monitoring, housekeeping and laundry. R1's Fall Incident Reports indicated on June 16, 2023, at 8:00 a.m., R1 was found on the floor, on his stomach, wrapped in blanket after attempting to self-transfer into his bed. R1's left thumb was swollen and R1 complained of pain. R1 was sent into the emergency department for evaluation and was diagnosed with a fracture to his left thumb. R1's record lacked evidence a MAARC report was filed after R1 obtained a fracture after a fall. On September 1, 2023, at 1:06 p.m., LALD-A stated she did not file a MAARC report at the time of R6's elopement or for R1's fracture from a fall. LALD-A stated she was unaware MAARC reports needed to be filed for injuries even though the injury was from a fall and it was determined the was an accident. The licensee's Vulnerable Adult, Maltreatment and Reporting policy dated April 15, 2022, indicated staff would immediately report suspected allegations of abuse, neglect or financial exploitation to MAARC. Immediately means as soon as possible, from the time the initial knowledge of the initial incident occurred.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03000	Continued From page 117 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (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." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 29, 2023, at 10:15 a.m., the surveyor toured the three buildings with unlicensed personnel (ULP)-D and ULP-D confirmed there	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(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
03090	Continued From page 118 was no signage observed posted at the entryway of the three buildings regarding electronic monitoring devices. During entrance conference on August 29, 2023, at 11:11 a.m., licensed assisted living director (LALD)-A stated there was no electronic monitoring signs posted in any of the three buildings and was unaware of the requirement. The licensee's Electronic Monitoring policy dated August 9, 2023, indicated signs would be installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *08/29/23*
Time: 11:00:00
Report: 1016231121

Food and Beverage Establishment Inspection Report

Location:

Heritage Haven Inc - Building 1
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

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

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

BLEACH SANITZER IN SPRAY BOTTLE MEASURED GREATER THAN 100 PPM. STAFF AND INSPECTOR DILUTED BOTTLE DURING INSPECTION.

Corrected on Site

4-300 Equipment Numbers and Capacities

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

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

A THIN PROBE THERMOMETER WAS NOT AVAILABLE. OBTAIN A THIN PROBE THERMOMETER.

Comply By: 08/30/23

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

ESTABLISHMENT HAD NO MEANS TO MONITOR DISH WASHER RINSE CYCLE TEMP. INSPECTOR PROVED THEMO-LABELS DURING INSPECTION.

Corrected on Site

Type: Full
Date: *08/29/23*
Time: 11:00:00
Report: 1016231121
Heritage Haven Inc - Building 1

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

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

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

A TEST KIT WAS NOT AVAILABLE FOR TESTING CONCENTRATION OF BLEACH SANITIZER. INSPECTOR PROVED TEST STRIPS.

Corrected on Site

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

BLEACH SPRY BOTTLE WAS NOT LABELED. LABEL ALL CHEMICALS.

Comply By: 08/29/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM WAS EMPLOYED. DIANE HOLMBERG STATE SHE HAD A SERVSAFE CERTIFICATE BUT COULD NOT PRODUCE THE DOCUMENT.

Comply By: 09/29/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

A HAND WASHING REMINDER SIGN WAS NOT POSTED AT HAND WASHING SINK. INSPECTOR PROVIDED A SIGN DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: > 100 PPM at Degrees Fahrenheit
Location:
Violation Issued: Yes

Chlorine: = 75 PPM at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Type: Full
Date: *08/29/23*
Time: 11:00:00
Report: 1016231121
Heritage Haven Inc - Building 1

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: GRAPES
Violation Issued: No

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

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

COMMENTS:

SAME DAY MEAL PREPARATION.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 1016231121 of 08/29/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
Diane Holmberg
PCA

Signed:_____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Report #: 1016231121

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

11 East Superior St.
Duluth

No. of RF/PHI Categories Out	3	**Date**	08/29/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Heritage Haven Inc Building 1	**Address** 3042 Morris Thomas Road	**City/State** Duluth, MN	**Zip Code** 55811	**Telephone** 2185905037
License/Permit # 0038310	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 08/29/23

Inspector (Signature)

Minnesota Department of Health

11 East Superior St.
Duluth

Food and Beverage Establishment Inspection Report

Type: Full
Date: *08/29/23*
Time: 11:15:00
Report: 1016231124

Location:

Heritage Haven Inc - Building 2
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
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.

3-200A Food Characteristics: approved source

3-201.11C ***** Priority 2 *****

MN Rule 4626.0130C Discontinue offering improperly labeled packaged food.

BLEACH SPRAY BOTTLE WAS NOT LABELED. STAFF LABELED SPRAY BOTTLE DURING INSPECTION.

Corrected on Site

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PIC DIANE DID NOT HAVE A CFPM CERTIFICATE. OBTAIN AND POST CFPM CERTIFICATE.

Comply By: 09/29/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

A HAND WASHING REMINDER SIGN WAS NOT POSTED AT HAND WASHING SINK. INSPECTOR PROVIDED SIGN DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 75 PPM at Degrees Fahrenheit
Location: BLEACH SPRAY BOTTLE
Violation Issued: No

Type: Full
Date: *08/29/23*
Time: 11:15:00
Report: 1016231124
Heritage Haven Inc - Building 2

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: GRAPES
Violation Issued: No

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

COMMENTS:

FOOD IS PREPARED AND EATEN ON THE SAME DAY.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

Type: Full
Date: *08/29/23*
Time: 11:15:00
Report: 1016231124
Heritage Haven Inc - Building 2

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 1016231124 of 08/29/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

Diane Holmberg
PCA

Signed:_____

Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *08/29/23*
Time: 11:30:00
Report: 1016231125

Food and Beverage Establishment Inspection Report

Location:
Heritage Haven Inc - Building 3
3042 Morris Thomas Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0038310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185905037
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
STAFF DID NOT HAVE A CFPM CERTIFICATE. OBTAIN AND POST CFPM CERTIFICATE.
Comply By: 09/29/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: TOMATO
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

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

COMMENTS:

FOOD IS PREPARED AND CONSUMED SAME DAY.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES

AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

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CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 1016231125 of 08/29/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____

Diane Holmberg
PCA

Signed:_____

Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us