



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

Electronically Delivered

April 8, 2025

Licensee  
Tradition  
8500 Tessman Farm Road North  
Brooklyn Park, MN 55445

RE: Project Number(s) SL25879016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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.

### **STATE CORRECTION ORDERS**

The enclosed State Form documents the state correction orders. MDH documents state licensing 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00**

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

**DOCUMENTATION OF ACTION TO COMPLY**

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.

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

**REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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 me.

Sincerely,



Jess Schoenecker, Supervisor  
State Evaluation Team  
Email: [jess.schoenecker@state.mn.us](mailto:jess.schoenecker@state.mn.us)  
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>25879</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRADITION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445</b>
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0 000	<p><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p>SL25879016-0</p> <p>On February 3, 2025, through February 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 155 residents; 48 receiving services under the Assisted Living Facility license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</b></p>	
0 470 SS=F	<p><b>144G.41 Subdivision 1 Minimum requirements</b></p> <p><b>(11) develop and implement a staffing plan for</b></p>	0 470		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 470	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> <li>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</li> <li>(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</li> <li>(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;</li> </ul> <p>(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:</p> <ul style="list-style-type: none"> <li>(i) awake;</li> <li>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</li> <li>(iii) capable of communicating with residents;</li> <li>(iv) capable of providing or summoning the appropriate assistance; and</li> <li>(v) capable of following directions;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors.</p> <p>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</p>	0 470		

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0 470	<p>Continued From page 2</p> <p>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).</p> <p>The findings include:</p> <p>The licensee held an assisted living license. The facility was licensed for a capacity of 160 residents and had a current census of 155 residents.</p> <p>During the entrance conference on February 3, 2025, at approximately 11:45 a.m., manager (M)-A and regional director of operations (RD)- H stated the licensee did not have a staffing plan that was reviewed at least twice per year.</p> <p>The licensee's 2.15 Staffing Plan policy revised February 2022, read "5. The staffing plan will be evaluated for the appropriateness of staffing levels in the facility and revised as needed at a minimum of two times per year".</p> <p>No further information was provided.</p> <p>TIME PERIOD OF CORRECTION: Seven (7) days</p>	0 470		
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p>	0 480		

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0 480	<p>Continued From page 3</p> <p>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;</p> <p>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;</p> <p>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;</p> <p>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food</p>	0 480		

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0 480	<p>Continued From page 4</p> <p>and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	<p>Continued From page 5</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>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) containing required assessment content was completed on admission for five of six residents (R2, R3, R4, R5, R6).</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2 was admitted to the licensee on June 1, 2016, under the licensee's former comprehensive license and remained an independent living (IL) resident (not receiving services) on August 1, 2021.</p> <p>R2's record lacked an IAPP.</p>	0 630		

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0 630	<p>Continued From page 6</p> <p><b>R3</b> R3 was admitted on March 5, 2022, as an IL resident. On February 21, 2024, R3 began receiving assisted living services.</p> <p>R3's unsigned service plan initiated on February 21, 2014, indicated R3's services included assistance with transfers, and housekeeping/laundry assistance.</p> <p>R3's record included a Vulnerability Assessment dated February 23, 2004. The assessment lacked a statement indicating R3's susceptibility to abuse by another individual, including other vulnerable adults.</p> <p><b>R4</b> R4 was admitted on October 18, 2012, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's unsigned service plan revised January 30, 2023, indicated R4's services included medication administration, bathing assistance, behavior management, and monthly vital signs.</p> <p>R4's record included a vulnerability assessment dated July 22, 2022. The assessment lacked a statement indicating R4's susceptibility to abuse by another individual, including other vulnerable adults.</p> <p><b>R5</b> R5 was admitted to the licensee on November 11, 2024, as an IL resident.</p> <p>R5's record lacked an IAPP.</p>	0 630		

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0 630	<p>Continued From page 7</p> <p>R6 R6 was admitted to the licensee on November 14, 2024, and began receiving assisted living services.</p> <p>R6's unsigned service plan initiated on November 20, 2024, indicated R6's services included occupational and physical therapy provided by a third party and pain management.</p> <p>R6's record included a Vulnerability Assessment dated November 21, 2024. The assessment lacked a statement indicating R6's susceptibility to abuse by another individual, including other vulnerable adults.</p> <p>On February 3, 2025, at 3:33 p.m., clinical nurse supervisor (CNS)-B stated "risk of abuse by others" was not part of the form in their electronic documentation system.</p> <p>On February 3, 2025, at 3:53 p.m., licensed assisted living director (LALD)-C stated they had not been completing IAPP assessments on their IL residents and had been giving them a questionnaire instead. LALD-C stated they would revise the electronic documentation forms to include all required elements in the IAPP.</p> <p>The licensee's 1.24 Vulnerable Adults and Maltreatment - Communication, Prevention, and Reporting policy dated August 1, 2021, indicated an abuse prevention plan would be completed for each resident in the assisted living by day 14 after move-in or receipt of services. The IAPP would be based upon the resident's susceptibility to abuse by another individual and the risk of abusing other vulnerable adults. The IAPP would also include specific measures to be taken to minimize the risk of abuse to others and</p>	0 630		

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0 630	Continued From page 8  self-abuse.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control  (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included maintaining a current Facility TB Risk Assessment and baseline screening and testing for one of two employees (unlicensed personnel (ULP)-D).	0 660		

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0 660	<p>Continued From page 9</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's Facility TB Risk Assessment dated March 31, 2024, lacked indication of the facility's risk for TB transmission.</p> <p>ULP-D was hired April 28, 2023, and began providing assisted living services.</p> <p>ULP-D's employee record included a negative chest x-ray result dated November 23, 2023.</p> <p>ULP-D's employee record lacked a TB history and symptom screen and results of a TB test predating the chest x-ray.</p> <p>On February 4, 2025, at approximately 10:15 a.m., manager (M)-A stated ULP-D's employee record lacked a TB screen and history and TB test because they were only doing chest x-rays at that time.</p> <p>On February 4, 2025, at approximately 11:15 a.m., M-A provided documentation dated February 4, 2025, indicating that a TB screen and history and a tuberculin skin test (TST) had been given to ULP-D during the survey.</p> <p>The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in</p>	0 660		

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0 660	<p>Continued From page 10</p> <p>Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."</p> <p>The licensee's Tuberculosis Screening of Employees policy revised March 11, 2021, indicated all employees would have a baseline TB screening performed by a licensed nurse consisting of the following components: -assessing for current symptoms; -assessing TB history; and -testing for TB with a TST or IGRA.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to</p>	0 775		

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0 775	<p>Continued From page 11</p> <p>affect residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On February 4, 2025, from 10:44am to 2:40 p.m., the surveyor toured the facility with the facility maintenance technician (MT)-F and regional maintenance (RM)-G.</p> <p>A fire door separating the kitchen from a stairwell corridor was damaged and altered. Holes were present in the door near the opening hardware of the fire door and the door was propped open with a rubber doorstop. The fire door must be maintained without alteration and its operation must not be obstructed by a doorstop to protect the stairwell by limiting the spread of smoke and fire. MT-F and RM-G acknowledged that holes were made in the door which would negate fire rating of the door and stated that it appeared that a new handle had been installed.</p> <p>Hallway fire doors were painted over, obscuring the fire rating placard and altering the door, on the second floor. Fire rating and informational placards must be maintained.</p> <p>High piled storage of decorations and plastic Christmas trees obstructed sprinkler heads in first floor storage room. The large plastic trees were stored directly in front of sprinkler head, which</p>	0 775		

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0 775	<p>Continued From page 12</p> <p>may impede water flow during a sprinkler activation. Emergency lights did not illuminate upon testing in activity parlor. MT-F expressed that emergency lights were recently tested and was surprised that that the lights were functional when tested.</p> <p>An escutcheon on a sprinkler head in the kitchen was damaged and hanging loosely from the sprinkler head.</p> <p>An escutcheon was missing around the sprinkler head in the bathroom of resident room 235.</p> <p>Stairway gate springs were not functional to pull barrier closed in stairwell B. The gate should be maintained to swing closed behind to direct egress outward during evacuation and serve as a guard against descending the stairs past the point of egress.</p> <p>Egress route from stairwell B was not shoveled and maintained free of obstruction to provide access to right of way. The exit area had significant snow and ice that had not been cleared. RM-G indicated that workers were hired to clear sidewalks and were supposed to have cleared a path from this stairwell.</p> <p>A television antenna was hanging from a sprinkler head in resident room 256. Sprinkler heads must be maintained free of obstruction to not impede water flow and to reduce risk of accidental activation of sprinkler head if hanging equipment damages the bulb within. MT-F stated that residents are instructed not to hang items from sprinkler heads in their units.</p> <p>The doors allowing access to the trash chutes on the third floor and first floor were open. The trash</p>	0 775		

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0 775	<p>Continued From page 13</p> <p>chute doors must be self-closing to protect vertical openings. MT-F demonstrated that springs were installed on trash chute doors but were no longer able to pull doors shut. Trash chute doors should be maintained to be self-closing.</p> <p>An exit sign located in the hallway near resident room 347 did not illuminate when tested. MT-F pressed the test button to simulate the sign being disconnected from building power and the sign ceased illumination.</p> <p>During the facility tour on February 4, 2025, these deficient conditions were visually verified by MT-F and RM-G accompanying on the tour and both stated that they understood requirements to comply with Minnesota State Fire Code under Minnesota Rules Chapter 7511.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 775		
0 790 SS=D	<p>144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment</p> <p>(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</p> <p>This MN Requirement is not met as evidenced</p>	0 790		

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0 790	<p>Continued From page 14</p> <p>by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>On February 4, 2025, from 10:44 a.m. to 2:40 p.m. the surveyor toured the facility with the facility maintenance technician (MT)-F and regional maintenance (RM)-G. It was observed that fire extinguishers in the activity parlor and the garage elevator lobby did not have current annual service tags or monthly checks, having been last serviced in October of 2023. The surveyor explained to MT-F and RM-G that the portable fire extinguishers are required to be annually replaced with a new extinguisher or serviced annually by a certified technician and that the current certification expired in March 2024. MT-F and RM-G stated that these extinguishers must have been missed during the annual servicing as all other extinguishers had been serviced by Summit in November of 2024.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 790		

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01470	Continued From page 15	01470		
01470 SS=D	<p><b>144G.63 Subd. 2 Content of required orientation</b></p> <p>(a) The orientation must contain the following topics:</p> <ul style="list-style-type: none"> <li>(1) an overview of this chapter;</li> <li>(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;</li> <li>(3) handling of emergencies and use of emergency services;</li> <li>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</li> <li>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</li> <li>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</li> <li>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</li> <li>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</li> <li>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.</li> </ul> <p>(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</p>	01470		

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01470	<p>Continued From page 16</p> <p>subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p>	01470		
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01470	<p>Continued From page 17</p> <p>ULP-E was hired on December 31, 2023, and began providing assisted living services.</p> <p>ULP-E's employee record lacked documentation of the following required orientation topics:</p> <ul style="list-style-type: none"> <li>-overview of assisted living statutes;</li> <li>-consumer advocacy services including information on the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</li> <li>-a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.</li> </ul> <p>On February 4, 2025, at 12:52 p.m., manager (M)-A stated the online module containing those orientation topics may have not gotten uploaded to ULP-E for completion. M-A stated the online education modules were uploaded in groups and this module may have been missed.</p> <p>On February 5, 2025, at approximately 8:30 a.m., M-A provided updated Educare (online education) transcripts for ULP-E indicating the online module containing the missing orientation topics had been completed by ULP-E on February 4, 2025 (during the survey).</p> <p>The licensee's 2.39 Orientation policy dated August 1, 2021, indicated orientation would include the following topics:</p> <ul style="list-style-type: none"> <li>-an overview of Minnesota's assisted living law;</li> <li>-types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and provider's scope of licensure; and</li> </ul>	01470		

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01470	Continued From page 18  -the complaint process including contact information for the Office of the Ombudsman for Long-Term Care and the Office of the Ombudsman for Mental Health and Disabilities.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	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 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	<p>Continued From page 19</p> <p>(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</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(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:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D).</p> <p>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</p>	01500		

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01500	<p>Continued From page 20</p> <p>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).</p> <p>The findings include:</p> <p>ULP-D was hired on April 28, 2023, and began providing assisted living services.</p> <p>ULP-D's employee record included an undated Educare (online training) transcript indicated ULP-D had completed annual training in March 2024. ULP-D's record lacked documentation the annual training completed in March 2024 included training on reporting of maltreatment of vulnerable adults under section 626.557.</p> <p>On February 4, 2025, at 12:52 p.m., manager (M)-A stated that ULP-D had not completed the required annual training. M-A stated that the training module was missed and not assigned to ULP-D.</p> <p>On February 5, 2025, at approximately 8:30 a.m., M-A provided surveyor with an undated Educare transcript indicating UPD-D had completed the required training on February 4, 2025 (during survey).</p> <p>The licensee's 3.08 Required Annual Staff Training policy updated on December 26, 2022, indicated annual training for staff would include reporting of maltreatment of vulnerable adults under section 626.557.</p> <p>No further information was provided.</p>	01500		

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01500	Continued From page 21  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(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.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day assessment for one of four residents (R6) and failed to ensure the RN conducted comprehensive nursing assessments within the required 90-day timeframe for three of</p>	01620		

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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
01620	<p>Continued From page 22</p> <p>three residents (R1, R3, R4).</p> <p>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 represents a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p><b>R1</b> R1 was admitted on November 30, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R1's unsigned, undated service plan, indicated R1's services included assistance with dressing and application and removal of compression stockings and weekly vital signs.</p> <p>R1's record included three consecutive nursing assessments dated December 12, 2023, March 12, 2024, and July 2, 2024.</p> <p>R1's consecutive nursing assessments completed on December 12, 2023, and March 12, 2024, indicated 91 days had passed between nursing assessments.</p> <p>R1's consecutive nursing assessments completed on March 12, 2024, and July 2, 2024, indicated 112 days had passed between nursing assessments.</p> <p><b>R3</b></p>	01620		

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01620	<p>Continued From page 23</p> <p>R3 was admitted on March 5, 2022, and began receiving assisted living services on February 21, 2024.</p> <p>R3's unsigned, undated service plan indicated R3's services assistance with grooming and transfers.</p> <p>R3's file included two consecutive comprehensive nursing assessments dated March 7, 2024, and December 17, 2024, indicating 195 days had passed between assessments.</p> <p>R4 R4 was admitted on October 18, 2012, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's unsigned, undated service plan indicated R4's services included medication administration, assistance with bathing, daily blood glucose checks, and weekly vital signs.</p> <p>R4's record included three consecutive comprehensive nursing assessments dated July 23, 2024, October 23, 2024, and January 27, 2025.</p> <p>R4's consecutive nursing assessments completed on July 23, 2024, and October 23, 2024, indicted 92 days had passed between assessments.</p> <p>R4's consecutive nursing assessments complete don October 23, 2024, and January 27, 2025, indicated 96 days had passed between assessments.</p> <p>R6</p>	01620		

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01620	<p>Continued From page 24</p> <p>R6 was admitted on November 14, 2024, and began receiving assisted living services.</p> <p>R6's undated, unsigned service plan indicated R6's services included pain monitoring and management and assistance with range of motion.</p> <p>R6's record lacked a 14-day comprehensive nursing assessment.</p> <p>On February 3, 2025, at 3:34 p.m., clinical nurse supervisor (CNS)-B stated there was a problem with assessment scheduling in Point Click Care (PCC; an electronic documentation system) and the assessments due to be completed were not showing up in time.</p> <p>On February 5, 2025, at 10:43 a.m., CNS-B stated the 14-day assessment for R6 had not been completed. CNS-B stated the scheduling in PCC was incorrect.</p> <p>The licensee's Nursing Assessment policy revised on January 2, 2024, read "A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment; b. 14-day Assessment: completed up to 14 days after start of services; c. Ongoing assessment: completed periodically but no less than every 90-days; d. Change in resident condition and Annually."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01620		

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01640	Continued From page 25	01640		
01640 SS=F	<p><b>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</b></p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure initial and revised service plans were authenticated by the resident or resident's representatives for four of four residents (R1, R3, R4, R6).</p> <p>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</p>	01640		

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01640	<p>Continued From page 26</p> <p>or represent a systemic failure that has affected or has the potential to affect a large number or all of the residents).</p> <p>The findings include:</p> <p><b>R1</b> R1 was admitted on November 30, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R1's unsigned, undated service plan indicated R1's services included assistance with dressing and application and removal of compression stockings and weekly vital signs.</p> <p><b>R3</b> R3 was admitted on March 5, 2022, and began receiving assisted living services on February 21, 2024.</p> <p>R3's unsigned, undated service plan indicated R3's services assistance with grooming and transfers.</p> <p><b>R4</b> R4 was admitted on October 18, 2012, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's unsigned, undated service plan indicated R4's services included medication administration, assistance with bathing, daily blood glucose checks, and weekly vital signs.</p> <p><b>R6</b> R6 was admitted on November 14, 2024, and began receiving assisted living services.</p>	01640		

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01640	<p>Continued From page 27</p> <p>R6's undated, unsigned service plan indicated R6's services included pain monitoring and management and assistance with range of motion.</p> <p>R1, R3, R4 and R6's service plans lacked authentication by the facility and by the resident or the resident's representative indicating agreement on the services to be provided.</p> <p>On February 5, 2025, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated they were unaware service plans required authentication and thought the assessments needed to be authenticated.</p> <p>The licensee's 4.09 Service Plans policy dated January 1, 2017, indicated an up-to-date service plan would be signed by an RN and the resident or the resident's representative.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01650 SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include:</p> <p>(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;</p> <p>(2) the identification of staff or categories of staff who will provide the services;</p> <p>(3) the schedule and methods of monitoring assessments of the resident;</p> <p>(4) the schedule and methods of monitoring staff</p>	01650		

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01650	<p>Continued From page 28</p> <p>providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3, R4, R6).</p> <p>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 the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1 R1 was admitted on November 30, 2018, under</p>	01650		

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01650	<p>Continued From page 29</p> <p>the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R1's unsigned, undated service plan indicated R1's services included assistance with dressing and application and removal of compression stockings and weekly vital signs.</p> <p>R1's service plan lacked the schedule and methods of monitoring staff providing services.</p> <p><b>R3</b> R3 was admitted on March 5, 2022, and began receiving assisted living services on February 21, 2024.</p> <p>R3's unsigned, undated service plan indicated R3's services assistance with grooming and transfers.</p> <p>R3's service plan lacked documentation of the following required information: -a description of all services provided (medication administration and blood glucose management); and -the schedule and methods of monitoring staff providing services.</p> <p><b>R4</b> R4 was admitted on October 18, 2012, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's unsigned, undated service plan indicated R4's services included medication administration, assistance with bathing, daily blood glucose checks, and weekly vital signs.</p>	01650		

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01650	<p>Continued From page 30</p> <p>R4's record included a service log dated January 2025, indicating staff were assisting with application and removal of Juxta-lite (compression) wraps twice daily.</p> <p>R4's service plan lacked documentation of the following required information: -a description of all services provided (assistance with compression garments); and -the schedule and methods of monitoring staff providing services.</p> <p>R6 R6 was admitted on November 14, 2024, and began receiving assisted living services.</p> <p>R6's undated, unsigned service plan indicated R6's services included pain monitoring and management and assistance with range of motion.</p> <p>R6's service plan lacked the schedule and methods of monitoring staff providing services.</p> <p>On February 4, 2025, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications and performing blood glucose monitoring on R3.</p> <p>On February 5, 2025, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated they were unaware of the required content for service plans. CNS-B stated the medication management and blood glucose monitoring were not on R3's service plan and R4's service plan did not include compression garment assistance.</p> <p>The licensee's 4.09 Service Plans policy dated January 1, 2017, read "The service plan must include all of the following required elements:</p>	01650		

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01650	Continued From page 31  1. A description of the home care services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the client's current review or assessment and client preferences ..."  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
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	01940		

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01940	<p>Continued From page 32</p> <p>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.</p> <p>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 three residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R3 was admitted on March 5, 2022, and began receiving assisted living services on February 21, 2024.</p> <p>R3's unsigned, undated service plan indicated R3's services assistance with grooming and transfers.</p> <p>R3's Medication/Treatment/Therapy Management Plan dated February 22, 2024, lacked the following required content: -documentation of specific resident instructions related to blood glucose management; and -procedures for notifying a registered nurse or</p>	01940		

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01940	<p>Continued From page 33</p> <p>appropriate licensed health professional when a problem arises with treatments or therapy services.</p> <p>On February 4, 2025, at 7:43 a.m., unlicensed personnel (ULP)-D was observed administering medications and checking blood glucose for R3.</p> <p>On February 4, 2025, at 10:49 a.m., the surveyor observed ULP-D checking blood glucose for R3.</p> <p>On February 5, 2025, at 10:49 a.m., clinical nurse supervisor stated parameters for notifying the nurse for blood glucose checks were not included in the treatment plan. CNS-B stated that diabetic management was not addressed in the assessment and did not carry forward to the treatment plan.</p> <p>The licensee's Medication and Treatment Plans policy revised on January 2, 2024, indicated the medication/treatment plan would be revised as needed, based on the results of required resident monitoring and /or reassessments.</p> <p>No further information was provided.</p> <p>TIME PERIOD OF CORRECTION: Seven (7) days</p>	01940		
01960 SS=D	<p>144G.72 Subd. 5 Documentation of administration of treatments</p> <p>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</p>	01960		

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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
01960	<p>Continued From page 34</p> <p>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 to meet the resident's needs.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of three residents (R4).</p> <p>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).</p> <p>The findings include:</p> <p>R4 was admitted on October 18, 2012, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's unsigned and undated service plan indicated R4's services included medication administration, bathing assistance, blood glucose monitoring, and behavior management.</p> <p>R4's record included a physician order for compression stockings dated July 3, 2024.</p> <p>R4's record included a service log dated January 2025, indicating R4 was receiving assistance with application and removal of Juxta-lite</p>	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>25879</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TRADITION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445</b>
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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
01960	<p>Continued From page 35</p> <p>(compression) wraps twice daily.</p> <p>R4's record lacked documentation of removal of Juxta-lite wraps on the following dates: January 2, 3, 6, 9, 16, 17, and 31, 2025.</p> <p>On February 5, 2025, at 10:28 a.m., clinical nurse supervisor stated the removal of R4's compression wraps had not been consistently documented through the month. CNS-B stated she was unsure why the ULPs were not documenting removal of the compression garments.</p> <p>The licensee's Resident Record policy dated August 5, 2021, indicated resident records would include documentation that services have been provided as identified in the service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD OF CORRECTION: Seven (7) days</p>	01960		



Type: Full  
Date: 02/03/25  
Time: 11:30:00  
Report: 1051251026

## Food and Beverage Establishment Inspection Report

**Location:**

Tradition  
8500 Tessman Farm Road North  
Brooklyn Park, MN55445  
Hennepin County, 27

**Establishment Info:**

ID #: 0038653  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7634167740  
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.

### 3-300B Protection from Contamination: cross-contamination, eggs

#### 3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

AT TIME OF INSPECTION, CONTAINERS OF SUGAR, FLOUR, AND PANKO WERE NOT LABELED.

Comply By: 02/03/25

### Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit

Location: 3-COMPARTMENT SINK

Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit

Location: DISHMACHINE

Violation Issued: No

### Food and Equipment Temperatures

Process/Item: Cold Line

Temperature: 41 Degrees Fahrenheit - Location: HARD BOILED EGGS-LEFT

Violation Issued: No

Process/Item: Cold Line

Temperature: 39 Degrees Fahrenheit - Location: EGG ROLLS-RIGHT

Violation Issued: No

Type: Full  
Date: 02/03/25  
Time: 11:30:00  
Report: 1051251026  
Tradition

# Food and Beverage Establishment Inspection Report

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Process/Item: Cooking  
Temperature: 160 Degrees Fahrenheit - Location: TATOR TOTS  
Violation Issued: No

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Process/Item: Prep Cooler  
Temperature: 41 Degrees Fahrenheit - Location: PASTA-MAIN LINE  
Violation Issued: No

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Process/Item: Walk-In Cooler  
Temperature: 41 Degrees Fahrenheit - Location: BEEF SCRAPS  
Violation Issued: No

---

Process/Item: Walk-In Cooler  
Temperature: 40 Degrees Fahrenheit - Location: DICED TOMATOES  
Violation Issued: No

---

Process/Item: Prep Cooler  
Temperature: 41 Degrees Fahrenheit - Location: RANCH CUP-SERVER STATION  
Violation Issued: No

---

Process/Item: Upright Cooler  
Temperature: 39 Degrees Fahrenheit - Location: CUT MELONS-SERVER STATION  
Violation Issued: No

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

MET WITH THE NURSE EVALUATOR, MICHELLE WINTERS.

DISCUSSED THE FOLLOWING WITH THE CULINARY DIRECTOR, AMBER:

EMPLOYEE ILLNESS LOG  
VOMIT CLEAN-UP PROCEDURE  
HANDWASHING & GLOVE USE

**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 1051251026 of 02/03/25.

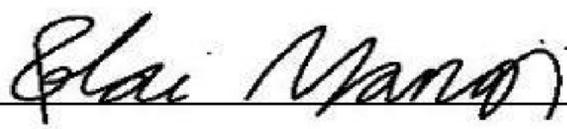
Certified Food Protection Manager: Amber J. Abubo

Certification Number: FM60239 Expires: 02/13/26

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

Signed: \_\_\_\_\_

Amber J. Abubo  
Culinary Director

Signed: 

Kai Yang  
Public Health Sanitarian 1  
St. Cloud  
320 640-3532

Type: Full  
Date: 02/03/25  
Time: 11:30:00  
Report: 1051251026  
Tradition

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# Food and Beverage Establishment Inspection Report



Kai.Yang@state.mn.us