Electronically Delivered

November 26, 2024

Licensee
The Kenwood
825 Summit Avenue
Minneapolis, MN 55403

RE: Project Number(s) SL30594015

Dear Licensee:

On October 23, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 24, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

August 26, 2024

Licensee
The Kenwood
825 Summit Avenue
Minneapolis, MN 55403

RE: Project Number(s) SL30594015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, 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.

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.

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.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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 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
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30594	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE KENWOOD	825 SUMMIT AVENUE MINNEAPOLIS, MN 55403

(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(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: SL30594015-0 On July 22, 2024, through, July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 35 residents; 35 receiving services under the provider's Assisted Living Facility license. An immediate order for tag identification 1290 was issued on July 22, 2024. An immediate order for tag identification 2310 was issued on July 23, 2024. The immediacy of the orders was removed effective July 23, 2024. Non-compliance remained and the scopes and levels remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 23, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 2 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure proper cleaning of shared medical equipment and ensure direct care staff appropriately gloved and performed adequate hand hygiene, for one of one staff (unlicensed personnel (ULP)-G). 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 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-G was hired May 15, 2024, to provide direct	0 510		

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0 510	Continued From page 3 cares and services to residents. SHARED MEDICAL EQUIPMENT On July 23, 2024, at 7:35 a.m., ULP-G was observed to remove a medication mediset (medication organizer) box from a locked medication cabinet and donned gloves. ULP-G then gathered a blood pressure cuff from their supply bag and, without sanitizing, placed the cuff around R5's left wrist. ULP-G obtained the blood pressure reading, removed the cuff, and without sanitizing, placed the cuff back into their supply bag. ULP-G gave R5's medications to them, doffed gloves, threw the gloves into a trash container, gathered their supply bag and without washing hands, exited the room. HANDWASHING On July 23, 2024, at 7:44 a.m., ULP-G entered R2's room and without washing or sanitizing hands, donned (applied) a pair of gloves. ULP-G remove a medication mediset box from a locked medication cabinet, placed the medications into a medication cup and gave the medications to R2. ULP-G then proceeded to make ULP-G's bed and gather the trash from the bathroom. Without doffing (removing) gloves, ULP-G exited R2's room with the bathroom trash, walked down the hallway to a room containing a trash chute. ULP-G doffed gloves and threw their gloves and trash from R1's room down the chute. On July 23, 2024, at 7:50 a.m., ULP-G knocked, entered R3's room, and without washing or sanitizing hands, donned a pair of gloves. ULP-G removed a medication mediset box from a locked medication cabinet and placed medications into a medication cup. ULP-G proceeded to assist R3 with morning cares, which included washing under R3's breasts and applying powder. ULP-G	0 510		

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0 510	Continued From page 4 doffed gloves and without washing or sanitizing hands, donned a new pair of gloves. ULP-G brought the medication cup to R3 and proceeded to assist with medication administration. ULP-G then assisted R3 to the bathroom and onto the toilet. ULP-G removed R3's used incontinent brief and applied a new one. Without doffing gloves, ULP-G was observed to leave the bathroom, drop her nametag onto the floor, pick up the nametag and place it into her pocket, gather R3's clothes from the dresser and return to the bathroom. ULP-G then gathered the trash from the bathroom and placed it into the trash bag from the bedroom. ULP-G doffed gloves and threw them into the bedroom trash container, without washing hands, ULP-G donned new gloves, assisted R3 to a standing position, cleaned R3's perineal area (region between the thighs), pulled up new brief and pants, and assisted R3 back to bed. Wearing the same gloves, ULP-G retrieved the telephone from the receiver in the living room and brought it to R3, doffed gloves, and threw gloves into the bedroom trash. Without washing or sanitizing hands, ULP-G gathered the trash and exited R3's room, walked down the hallway to room containing a trash chute, and threw the trash down the chute. On July 23, 2024, at 8:20 a.m., ULP-G stated they had been trained by the RN on handwashing technique. ULP-G further stated they should have washed hands for at least 20 seconds before and after working with residents, but they "sometimes forget." On July 23, 2024, at 9:15 a.m., registered nurse (RN)-B stated the ULPs were instructed to wash hands between cares and sanitize shared medical equipment before each use.	0 510		

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0 510	Continued From page 5 The CDC guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated November 29, 2022, indicated shared medical equipment such as blood pressure cuffs should be cleaned and reprocessed (disinfected or sterilized) prior to use on another patient or when soiled. The CDC guidance further indicated healthcare personnel (HCP) should perform hand hygiene immediately before touching a patient, after touching a patient or the patient's immediate environment and immediately after glove removal. The licensee's Hand Hygiene policy dated February 22, 2024, included "When hands should be washed. Handwashing will be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace handwashing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body to clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using the restroom." The licensee's Procedure for Using Gloves policy dated February 22, 2024, included "Gloves are to be worn whenever there may be direct contact between the caregivers hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container." The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated	0 510		

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0 510	Continued From page 6 February 22, 2024, indicated "Reusable equipment and environmental surfaces will be properly disinfected after use. Whenever possible, clients will have their own reusable equipment and the equipment will not be shared with other clients or residents." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	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 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 observation, interview, and record review, the licensee failed to accurately identify all areas of vulnerability on the individual abuse prevention plan (IAPP) for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 7 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 23, 2024, during continuous observations from 7:44 a.m., to 8:10 a.m., unlicensed personnel (ULP)-G was observed to assist R2 and R3 with morning cares and administer medications from a locked medication container stored in each resident's kitchen cabinet. On July 23, 2024, at 7:50 a.m., the surveyor observed ULP-F obtain and administer R4's medications from a medication container stored in R4's locked kitchen cabinet. After ULP-F provided medications to R4, ULP-F documented the administration in R4's medication administration record (MAR). R2 R2 was admitted on September 26, 2023, and had diagnoses which included type 2 diabetes and cerebral infarction (brain injury due to lack of oxygen to brain cells). R2's service plan dated January 1, 2024, indicated R2 received services to include assistance with bathing and medication management. R2's IAPP dated July 2, 2024, indicated R2 had no susceptibility of sexual abuse, physical abuse, self-abuse, and financial exploitation. R3	0 630		

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0 630	Continued From page 8 R3 was admitted on January 3, 2023, and had diagnoses which included anemia (low red blood cells) and chronic pain. R3's service plan dated April 20, 2023, indicated R3 received services to include assistance with bathing, housekeeping, and medication management. R3's IAPP dated June 26, 2024, indicated R3 had no susceptibility of sexual abuse or physical abuse. R4 R4 was admitted on December 15, 2023, and had diagnosis which included unspecified dementia (memory loss), adjustment disorder with anxiety (a mental health disorder), and insomnia (sleep disorder). R4's signed service plan dated December 15, 2023, indicated R4 received services to include assistance with evening personal cares, and medication management. R4's IAPP dated May 6, 2024, indicated R4 had no susceptibility of sexual abuse, physical abuse, self-abuse, and financial exploitation. R2, R3, and R4's IAPPs lacked an accurate assessment of: -susceptibility to abuse by another individual, including other vulnerable adults. On July 24, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she considered the residents who received services, which included R2, R3, and R4 to be vulnerable to the susceptibility of sexual abuse, physical abuse, self-abuse, and financial exploitation. Also,	0 630		

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0 630	Continued From page 9 CNS-B verbalized she planned to update R2, R3 and R4's IAPPs to ensure they accurately reflected the residents' vulnerabilities. The licensee's Vulnerable Adult Maltreatment policy dated February 22, 2024, included "PROCEDURE: 1. An abuse prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services. 2. The individual abuse prevention plan will include a. Be based upon an individualized review or assessment of the resident's i. susceptibility to abuse by another individual, including other vulnerable adults ii. risk of abusing other vulnerable adults b. specific measures to be taken to minimize the risk of abuse to others and self-abuse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	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 and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 10 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 the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-D). 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). The findings include: On July 23, 2024, between 7:15 a.m., and 7:35 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. ULP-D started employment with the licensee on February 28, 2023, to provide assisted living services. ULP-D's employee record lacked evidence of	0 650		

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0 650	Continued From page 11 documentation of an annual performance review to identify areas of improvement needed and training needs. On July 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-A stated ULP-D's annual performance review was not in her employee record or completed in 2023. Also, LALD-A indicated ULP-D resigned for a short period of time in 2023. LALD-A verbalized she agreed ULP-D's annual performance review was overdue to be completed. On July 24, 2024, at 1:55 p.m., LALD-A stated, via email, "[ULP-D's] resignation and last day was 6/23/23 [June 23, 2023]. Her first day back was 8/10/23 [August 10, 2023]. We will do her annual review next week and submit." The licensee's Personnel Records policy dated February 22, 2024, included "2. The personnel record for each person will include: a. Evidence of current professional licensure, registration or certificate, if licensure, registration, or certification is required by the law or other state requirements; b. Record of orientation: c. Record of all required training for unlicensed personnel and competency determinations; d. Record of required in-service education for all staff providing services to clients, including annual training's and infection control training; e. Documentation of a completed background study; f. Documentation that the employee is not on the OIG or MHCP exclusion list: g. TB screening results (and other documentation related to communicable diseases, if appropriate); h. Results of supervision observations	0 650		

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0 650	Continued From page 12 i. Performance evaluations which identify areas of improvement needed and training needs. j. Current job description, which includes qualifications, responsibilities and identification of supervisors." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 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;	0 780		

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0 780	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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, 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 July 22, 2024, from approximately 12:00 p.m. to 2:00 p.m., survey staff toured the facility with director of maintenance (DM)-C. Survey staff asked DM-C to initiate a test of the smoke alarms in multiple apartments. Upon testing, the smoke alarms in the following locations did not meet the minimum statute requirements: 1. Apartment 1506, 1512, 1401, 1404, 1208, 1203, 1003, 905, 810, 702, 610, 504, 405, and 311 did not have smoke alarms installed in the bedrooms. 2. The smoke alarms in each apartment were not interconnected. These deficient conditions were visually verified by DM-C accompanying on the tour.	0 780		

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0 780	Continued From page 14 On July 22, 2024, at 1:00 p.m., DM-C stated they knew there were not smoke alarms installed in most of the apartment bedrooms. Survey staff reviewed the statute requirements for smoke alarms with DM-C. DM-C stated they understood the requirements and would bring the apartments into compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

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0 800	Continued From page 15 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 July 22, 2024, from approximately 12:00 p.m. to 2:00 p.m., survey staff toured the facility with director of maintenance (DM)-C. The following was observed. The trash chute doors on floors 15, 14, and 12 did not shut and latch on their own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. The trash room doors on floors 12, 10, and 8 did not shut and latch on their own. All trash room doors should close and latch completely to maintain the fire resistance rating of the construction system. DM-C did not have a key that would open apartment 501. DM-C stated the master key was recently cut and some of the older locks in the building did not work with the key. On July 22, 2024, at 2:30 p.m., DM-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 16 (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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required	0 810		

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0 810	Continued From page 17 content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 22, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Emergency - Internal", undated, failed to include the following: The FSEP included standard employee procedures for a shelter-in-place fire plan but failed to provide specific employee actions to take in the event of a fire evacuation or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should	0 810		

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0 810	Continued From page 18 follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On July 22, 2024, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A provided documentation showing staff received training once, but was unable to provide documentation showing any additional training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. On July 22, 2024, at 2:30 p.m., LALD-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of the licensee's evacuation drill log indicated evacuation drills were conducted on October 18, 2022, December 14, 2022, June 23,	0 810		

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0 810	Continued From page 19 2023, August 2, 2023, September 19, 2023, December 20, 2023, January 26, 2024, April 10, 2024, and June 11, 2024. No other documentation was provided. On June 4, 2024, at 2:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	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 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 the employee had a cleared Minnesota (MN) Department of Human Services (DHS) NETStudy 2.0 background study for one of four employees (dining director (DD)-E). This had the potential to	01290		

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01290	Continued From page 20 affect all residents in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: DD-E was hired July 6, 2020, to provide dining services to residents. On July 22, 2024, at 1:40 p.m., DD-E was observed in the second-floor dining preparation area of the facility. DD-E's employee record included an unaffiliated DHS background study dated June 22, 2020. On July 22, 2024, at 1:50 p.m., the surveyor reviewed the DHS NETStudy 2.0 Roster licensed assisted living director (LALD)-A. DD-E's background study was not affiliated with the licensee's health facility identification (HFID) number 30594. On July 22, 2024, at 2:00 p.m., LALD-A stated she also noticed that DD-E was not affiliated to the licensee and DD-E would need to be fingerprinted. On July 22, 2024, at 2:13 p.m., the surveyor supervisor provided the surveyor DD-E's NETStudy 2.0 background study results. DD-E's background study was completed for the	01290		

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01290	Continued From page 21 provider's closed comprehensive home care license (HFID 20341) on June 20, 2020, and not affiliated to the current licensee. As of December 31, 2022, DD-E's background study indicated "Eligible-Covid-19 Study Expired." On July 22, 2024, at 2:15 p.m., LALD-A stated there were a few residents who like to eat in their room and DD-E would enter a resident's room to drop off a food tray. The MN DHS website Frequently Asked Questions (FAQ's) on Background Studies updated July 20, 2023, indicated emergency studies initiated during the COVID-19 pandemic were no longer valid. The website indicated, "If an individual who is still affiliated has not had a new fingerprint-based background study submitted since their emergency study expired, then your entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one." The licensee's Screening of Job Applicant policy dated February 22, 2024, included "All job applicants will be screened to assure compliance with applicable state laws and our facility's requirements, including background checks and screening for TB. No new employee will have unsupervised direct contact with clients until all required screenings have been satisfactorily completed and any applicable licenses, registrations or certifications have been verified." No further information was provided. TIME PERIOD OF CORRECTION: Immediate	01290		

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01290	Continued From page 22 The immediacy of the order was removed effective July 23, 2024. Non-compliance remained and the scope and level remain unchanged.	01290		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure agency (also known as temporary or contracted) staff met the same training requirements as licensee personnel for one of one agency staff (clinical nurse supervisor (CNS)-B). 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 July 22, 2024, through July 24, 2024, during the course of the survey, the surveyor observed CNS-B perform managerial duties and provide supervision to the unlicensed staff.	01350		

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01350	Continued From page 23 CNS-B was an agency staff and started working for the licensee on January 15, 2024. CNS-B's record lacked the following required orientation: - person-centered planning/service delivery. On July 24, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A stated she thought CNS-B had all the required orientation. On July 25, 2024, at 10:13 a.m., LALD-A provided documentation of person-centered care principles training for CNS-B, completed on July 24, 2024 (after initiation of the survey). The licensee's Assisted Living & Assist Living with Memory Care Orientation-All Staff policy, dated February 22, 2024, indicated all new hires would receive orientation and training on topics required for assisted living organizations, including principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01350		
01370 SS=D	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	01370		

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01370	Continued From page 24 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; (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 training was completed for all required areas, prior to providing services, for two of three unlicensed personnel ((ULP)-D, ULP-G).	01370		

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01370	Continued From page 25 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). The findings include: On July 23, 2024, between 7:15 a.m., and 7:35 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. On July 23, 2024, during continuous observations from 7:44 a.m., to 8:10 a.m., ULP-G was observed to assist R2 and R3 with medication management and morning cares. ULP-D ULP-D started employment with the licensee on February 28, 2023, to provide assisted living services. ULP-D's record lacked training in the following required area: -standby assistance techniques and how to perform them. ULP-G ULP-G was hired May 15, 2024, to provide assisted living services. ULP-G's record lacked training in the following required area: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aides; -dressing and assisting with toileting; and	01370		

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01370	Continued From page 26 -standby assistance techniques and how to perform them. On July 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-A stated the nurses provided the ULPs with the competency skills, but LALD-A had not assigned all the required training courses to ULP-D and ULP-G in the licensee's online training program to be completed. LALD-A verbalized she planned to get these courses assigned to ULP-D and ULP-G. On July 24, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated she completed the competencies of skills on delegated tasks for the ULPs and was not aware there was additional training content to be completed. The licensee's undated Assisted Living Orientation - ULP Staff policy indicated "16. Training and skills demonstration for ULPs who are not NARs [certified nursing assessments] in addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration: a. Hair care b. Bathing c. Care of teeth, guns, and oral prosthetic devices d. Care and use of hearing aids e. Dressing f. Assisting with toileting g. Standby assistance techniques". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 27	01380		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed for all required areas, prior to providing services, for two of three unlicensed personnel ((ULP)-D, ULP-G). 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). The findings include:	01380		

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01380	Continued From page 28 On July 23, 2024, between 7:15 a.m., and 7:35 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. On July 23, 2024, during continuous observations from 7:44 a.m., to 8:10 a.m., ULP-G was observed to assist R2 and R3 with medication management and morning cares. ULP-D started employment with licensee on February 28, 2023, to provide assisted living services. ULP-D's record lacked training in the following required area: -range of motioning and positioning. ULP-G ULP-G was hired May 15, 2024, to provide assisted living services. ULP-G's record lacked training in the following required area: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On July 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-A stated the nurses provided the ULPs with the competency skills, but LALD-A had not assigned all the required training courses to ULP-D and ULP-G in the licensee's online training program to be completed. LALD-A verbalized she planned to get these courses assigned to ULP-D and ULP-G.	01380		

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01380	Continued From page 29 On July 24, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated she completed the competencies of skills on delegated tasks for the ULPs and was not aware there was additional training content to be completed. The licensee's undated Assisted Living Orientation - ULP Staff policy indicated "16. Training and skills demonstration for ULPs who are not NARs [certified nursing assistants] In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration: a. Hair care b. Bathing c. Care of teeth, guns, and oral prosthetic devices d. Care and use of hearing aids e. Dressing f. Assisting with toileting g. Standby assistance techniques h. Medication reminders i. Exercise reminders j. Treatment reminders k. Reading and Recording temperature, pulse and respirations of the resident l. Safe transfer techniques and ambulation m. Range of motion n. positioning o. Administering medications and/or treatments as required". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01440	Continued From page 30	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for one of three employees (unlicensed personnel (ULP)-D). 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	01440		

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01440	Continued From page 31 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). The findings include: On July 23, 2024, between 7:15 a.m., and 7:35 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. ULP-D started employment with licensee on February 28, 2023, to provide assisted living services. ULP-D's record included a "Notes on supervision of nursing staff" dated January 8, 2024, and June 15, 2024, but lacked evidence a registered nurse (RN) conducted direct supervision within 30 calendar days of performing delegated tasks from ULP-D's date of hire. On July 24, 2024, at 9:20 a.m., the licensed assisted living director (LALD)-A stated the licensee missed having an RN complete a 30-day supervision of staff, by observation, within 30 days of performing delegated tasks. On July 24, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B verbalized there was a different nurse employed at the time ULP-D was hired, and the 30-day RN supervision was not completed on time. The licensee's Supervision of Unlicensed Personnel policy dated February 22, 2024, included "PROCEDURE: 1. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or	01440		

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01440	Continued From page 32 Assigned Therapy Services. a. Direct Supervision of Staff Providing Delegated Tasks. Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned. The RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies. After the initial period of direct supervision, the RN and/or LPN will determine the frequency of ongoing, additional direct supervision based on the individual staff person's performance and on the needs and condition of individual clients, the types of services being provided and the experience of the staff." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 33 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470		

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01470	Continued From page 34 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 interview and record review, the licensee failed to ensure employee's received orientation to include all required content for two of three employees (unlicensed personnel (ULP)-D, ULP-G). 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). The findings include: ULP-D and ULP-G were hired February 28, 2023, and May 15, 2024, respectively, to provide assisted living services to the licensee's residents. ULP-D ULP-D's record lacked documentation the following required orientation topics were completed: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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01470	Continued From page 35 Facility Complaints. ULP-G ULP-G's employee record contained and education transcript from another licensee, but lacked documentation the following orientation topics were completed for the current licensee: - Overview of assisted living statutes; - Reporting maltreatment of vulnerable adults or minors; - Assisted living bill of rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Principles of person-centered planning/service delivery. On July 24, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed ULP-D and ULP-G had not completed the above listed required orientation topics. On July 24, 2024, at 11:37 a.m., licensed assisted living director (LALD)-A stated she thought the training records provided from ULP-G's previous employment would be sufficient, and she was not aware the orientation was not transferable. The licensee's Assisted Living Orientation - All Staff policy dated February 22, 2024, included "POLICY: Newly hired staff will receive orientation and training on topics required for assisted living organizations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01500	Continued From page 36	01500		
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; (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.	01500		

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01500	Continued From page 37 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 at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D). 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 July 23, 2024, between 7:15 a.m., and 7:35	01500		

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01500	Continued From page 38 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. ULP-D had a hire date of February 28, 2023. ULP-D's training record lacked any evidence of the eight hours annual training requirement to include all the required content below: -Reporting maltreatment of vulnerable adults or minors; -Assisted living bill of rights; -Infection control techniques; -Review of provider's policies and procedures; and -Principles of person-centered planning/service delivery. On July 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-A stated she was unable to find additional evidence of annual training for ULP-D, and some of the required annual trainings were not completed. LALD-A further verbalized she planned to have ULP-D get these trainings completed. The licensee's Assisted Living Annual Training dated February 22, 2024, included "1. All assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557 b. Assisted living bill or rights c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights d. Infection control techniques used in the home and implementation of infection control standards including i. Hand washing ii. Need for and use of protective gloves,	01500		

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	30594	A. BUILDING: _____ B. WING _____	07/24/2024

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01500	Continued From page 39 gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease, or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training 2. Annual training will be documented in accordance with the documentation policy. 3. Direct-care staff will complete 8 hours of annual training for each 12 months of employment." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

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01530	Continued From page 40 specified under paragraph (b) within 120 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; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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 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 employees had completed at least eight (8) hours of initial dementia training within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP-D). 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	01530		

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01530	Continued From page 41 situation has occurred only occasionally). The findings include: On July 23, 2024, between 7:15 a.m., and 7:35 a.m., the surveyor observed ULP-D administer medications to the licensee's residents. ULP-D stated to the surveyor was employed full-time with the licensee for over a year. ULP-D started employment with licensee on February 28, 2023, to provide assisted living services. ULP-D's employee record included 5.75 hours of dementia training, missing 1.25 hours of the required eight hours within 160 hours of employment start date. The licensee's weekly schedule dated July 1, 2024, through July 24, 2024, indicated ULP-D was scheduled to work full-time Monday through Friday, weekly, on the day shift for eight hours per day. On July 24, 2024, at 9:20 a.m., licensed assisted living director (LALD)-A stated she was not able to find additional evidence of documented dementia training for ULP-D. Also, LALD-A verbalized ULP-D did not have the full eight hours of dementia care training completed on her training transcripts. The Assisted Living Dementia Training policy dated February 22, 2024, included "PROCEDURE: 1. Employees of a licensed assisted living or a licensed assisted living with dementia care who have not completed their initial dementia care training will not provide direct care independently:	01530		

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01530	Continued From page 42 i. There will be another employee onsite while this employee is working who 1. completed the initial eight hours of training on topics related to dementia care 2. will serve as a resource for the employee who has not completed all of the initial dementia care training ii. A trainer or supervisor will be available for consultation with the new employee until the training requirement is complete." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced	01610		

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01610	Continued From page 43 by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial nursing assessment of the physical and cognitive needs of a prospective resident prior to the date the resident moved in for two of three residents (R2, R3). 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 July 23, 2024, during continuous observations from 7:44 a.m., to 8:10 a.m., ULP-G was observed to assist R2 and R3 with medication management. and morning cares. R2 R2 was admitted on September 26, 2023, and had diagnoses which included type 2 diabetes and cerebral infarction (brain injury due to lack of oxygen to brain cells). R2's service plan dated January 1, 2024, indicated R2 received services to include assistance with bathing and medication management. R3 R3 was admitted on January 3, 2023, and had diagnoses which included anemia (low red blood	01610		

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01610	Continued From page 44 cells) and chronic pain. R3's service plan dated April 20, 2023, indicated R3 received services to include assistance with bathing, housekeeping, and medication management. R2 and R3's records lacked an initial nursing assessment of physical and cognitive needs. On July 24, 2024, at 9:50 a.m., licensed assisted living director (LALD)-A stated R2 and R3's initial assessments were missing, and she guessed it was "because of the changeover in nursing." On July 24, 2024, at 10:30 a.m., registered nurse (RN)-B stated regarding R2 and R3's assessments, "unfortunately when I opened them [initial nursing assessments] they were not complete." The licensee's Initial and On-going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated February 22, 2024, indicated the registered nurse would assess the physical, mental, and cognitive needs of the resident as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01760 SS=D	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	01760		

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01760	Continued From page 45 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 medication administration was documented accurately for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 23, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F obtain and administer R4's medications from a locked medication container stored in R4's kitchen cabinet. After ULP-F provided medications to R4, ULP-F documented the administration in R4's medication administration record (MAR). R4 was admitted on December 15, 2023, and had	01760		

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01760	Continued From page 46 diagnoses which included unspecified dementia (memory loss), adjustment disorder with anxiety (a mental health disorder), and insomnia (sleep disorder). R4's "2024 Addendum A (section IV-2)" service plan signed November 21, 2023, indicated R4 received assistance with evening cares and medication management. R4's MAR dated July 2024, lacked documentation of medication administration or refusal of medications for the following dates and times: -July 1, at 9:00 p.m.; -July 2, 4, 9, 10, 21, and 22, at 2:00 p.m.; and -July 5, 19, and 21, at 8:30 a.m. On July 24, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee's current electronic medical record has been challenging to use for the temporary employees. CNS-B agreed R4 had some undocumented medications to be administered as well as no entry or reason why the medication was not administered. Further, CNS-B stated she was looking forward to the licensee obtaining a new electronic medical record platform that could improve the documentation of residents' medication administration. The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated February 22, 2024, included "PROCEDURE: 1. Staff will document each task immediately after that task has been performed. 2. Documentation will follow professional standards for documentation, including the requirement that entries must be: a. Legible; b. Permanently recorded in black/blue ink or in	01760		

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01760	Continued From page 47 electronic form; c. Dated with the time of entry; d. Authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the client record, the person will authenticate initials with a full signature and title. The signature and title may be included on the same document or on the EMR; e. Entries in the client record will never be redacted. If there is an error in an entry in paper documentation, draw one line through the erroneous entry, making sure that the inaccurate information is still legible. Initial and date the entry. State the reason for the error (i.e. in the margin or above the note if room) and document the correct information; and f. Staff will use only approved health care abbreviations identified by the RN and agency." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R4).	01830		

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01830	Continued From page 48 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). The findings include: On July 23, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F obtain and administer R4's medications from a locked medication container stored in R4's kitchen cabinet. After ULP-F provided medications to R4, ULP-F documented the administration in R4's medication administration record (MAR). R4 was admitted on December 15, 2023, and had diagnoses which included unspecified dementia (memory loss), adjustment disorder with anxiety (a mental health disorder), and insomnia (sleep disorder). R4's signed service plan dated December 15, 2023, indicated R4 received services to include assistance with evening personal cares and medication management. R4's MAR dated July 2024, indicated R4 received administration of medications which required a current authenticated prescriber order. R4's medical record included a prescriber signed document titled "Current Ongoing Care Plan" dated April 8, 2024, which included the name of medications R4 received, but lacked the required prescription information of medication dosage, route, and time.	01830		

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01830	Continued From page 49 R4's medical record lacked a current signed prescriber orders for all medications R4 received. On July 24, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B reviewed with the surveyor R4's prescriber signed orders. CNS-B further stated R4's signed provider orders dated April 8, 2024, were missing the full medication prescription information of dosage, route, and time. In addition, CNS-B verbalized the licensee's electronic medical record sometimes will not print the full information and this may have been what happened with R4's current signed prescriber's orders. The licensee's undated Medication Prescriptions and Refills policy included "5. The RN or LPN will assure that the prescriber renews a medication order at least every 12 months, or more frequently if determined necessary based on the nursing assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 50 review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. 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 of the residents). The findings include: On July 22, 2024, at 12:25 p.m., the surveyor observed the licensee's medication refrigerator located in the nursing office with unlicensed personnel (ULP)-D. In the presence of ULP-D, the surveyor observed the contents of the medication refrigerator that included one unopened vial of Lispro insulin utilized for a resident at the facility. The surveyor requested the daily temperature log. ULP-D stated she was not sure if there was a temperature log. On July 22, 2024, at 12:30 p.m. clinical nurse supervisor (CNS)-B stated they did not monitor or keep a log of the temperature of the medication refrigerator. Also, CNS-B verbalized she planned to get a temperature log created for the licensee's medication storage refrigerator to be monitored daily. The manufacturer's instructions for Lispro insulin vial dated September 18, 2023, indicated to store unopened Lispro insulin vial in a refrigerator at 36º Fahrenheit (F) (a temperature scale) to 46º F	01880		

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01880	Continued From page 51 until the expiration date. Also, included "Do not freeze and do not use if it has been frozen." The licensee's Storage of Medications policy dated February 22, 2024, indicated "2. Proper Storage of Medications a. The RN will recommend where medications should be stored understanding that our agency may not be able to control where and how a client stores his/her medications in their room. The RN will provide education to the client/client's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the client's room and the nursing office." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	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 monitor for expired medications for two of three residents (R4, R5).	01890		

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01890	Continued From page 52 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 July 22, 2024, at 10:30 a.m., during entrance conference, clinical nurse supervisor (CNS)-B indicated the licensee provided medication administration to residents. On July 23, 2024, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R5 with blood glucose testing and insulin administration. The surveyor observed R5's personal apartment refrigerator and found two boxes of Humulin (intermediate acting) insulin in the side door of refrigerator with an expiration date of February 2022. ULP-D stated she had not seen the boxes of insulin in R5's refrigerator before this observation. Also, ULP-D verbalized R5's family may have placed the boxes of insulin in the refrigerator. On July 23, 2024, at 7:35 a.m. the surveyor observed ULP-F assist R4 with medication administration. The surveyor observed in R4's locked medication cabinet one Ventolin inhaler with an expiration date of April 2024. ULP-F stated she would bring the expired Ventolin inhaler to the nurse. R4 R4 was admitted on December 15, 2023, and had	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30594	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE KENWOOD	825 SUMMIT AVENUE MINNEAPOLIS, MN 55403

(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
01890	Continued From page 53 diagnoses which included unspecified dementia (memory loss), adjustment disorder with anxiety (a mental health disorder), and insomnia (sleep disorder). R4's signed service plan dated December 15, 2023, indicated R4 received services to include assistance with evening personal cares and medication management. R5 R5 was admitted on January 24, 2022, and had diagnoses which included type 2 diabetes (insulin dependent) and insomnia (difficulty with sleep). R5's signed service plan dated March 28, 2024, indicated R5 received services to include assistance with blood glucose monitoring and medication administration. On July 23, 2024, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of how the insulin in R5's apartment refrigerator got there and possibly came from the family. Also, CNS-B stated ULP-F brought the expired Ventolin inhaler to her and she planned to have it disposed. Further, CNS-B verbalized the nurses check the medication boxes every week, but these must have been missed. The manufacturers Highlights of Prescribing Information for Humulin insulin dated June 2022, indicated the unopened Humulin insulin vials should be stored in a refrigerator at 36º Fahrenheit (F) (a temperature scale) to 46º F until the expiration date. Also, included "Protect from heat and light. Do not freeze. Do not use if it has been frozen." The licensee's Storage of Medications policy	01890		

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	30594	A. BUILDING: _____ B. WING _____	07/24/2024

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THE KENWOOD	825 SUMMIT AVENUE MINNEAPOLIS, MN 55403

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01890	Continued From page 54 dated February 22, 2024, indicated "2. Proper Storage of Medications b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 two of two residents who utilized consumer bed rails (R2, R4). This resulted in issuance of an immediate correction order on July 23, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30594	A. BUILDING: _____ B. WING _____	07/24/2024

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THE KENWOOD	825 SUMMIT AVENUE MINNEAPOLIS, MN 55403

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02310	Continued From page 55 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, during observations from 7:45 a.m. through 9:05 a.m., the surveyor observed consumer style bed rails on the upper left and upper right side of R2 and R4's beds, respectively. R2's bed rail was observed to be very loose. R2's diagnoses included cerebral infarction (brain injury due to lack of oxygen to brain cells), unspecified. R4 diagnoses included dementia and muscle weakness. R2 and R4's service plans both dated January 1, 2024, indicated services included assistance with activities of daily living and medication management. R2 and R4's records lacked: -Documentation of use, installation, and maintenance according to manufacturer's guidelines; -Documentation the Consumer Product Safety Commission (CSPC) website was reviewed regularly for recalls; and -Documentation of physical inspection of bed rails/mattresses for areas of entrapment, stability, and correct installation.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30594	A. BUILDING: _____ B. WING _____	07/24/2024

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02310	Continued From page 56 On July 23, 2024, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated, there were no manufacturer directions for R2 or R4. CNS-B also verbalized the licensee did not have any manufacturer instructions for the licensee's residents who had a consumer style bed rail. In addition, CNS-B stated the licensee did not have evidence the CSPC website was checked for recalls. On July 23, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated she had not retained the manufacturer's information for the consumer bedrails and did not have documentation that the CPSC recall website had been checked. On July 23, 2024, at 12:50 p.m., director of maintenance (DM)-C stated he had not been checking the consumer bedrails for maintenance. The Medline Bed Assist Bar User Guide dated December 15, 2009, included on page three "ASSEMBLY INSTRUCTIONS, DO NOT install this product without first reading and understanding this instruction sheet. If you are unable to understand these warnings, cautions, and instructions, contact a healthcare professional or dealer before attempting to install this equipment. Failure to follow instructions may result in serious injury." The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 57 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Device and Device Assessment policy dated January 16, 2024, included "POLICY: 5. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles. 6. Grab bars that are either placed/attached or strapped between the mattress and box spring or bed frame are not allowed in our building. If the facility staff learn of a device like this on a bed it will be removed and alternatives will be discussed with the resident/responsible party. 7. If a resident needs a device to assist with bed mobility the preferred device is a Halo. This device can be safely placed on a residential bed." In addition, included "PROCEDURE: 3. Devices will be installed as appropriate for the type of bed: -For hospital beds: Device will be installed per FDA guidelines; and -For non-hospital beds: Devices will be installed according to the device manufacturer's instructions." Finally, indicated "6. Physical devices will be assessed for safety during each re-assessment. If there are any safety issues identified, the Director of Health Services, or Housing Director will be notified immediately. 7. Maintenance staff will inspect bed and mattress for zone safety on a monthly basis. 8. Maintenance staff will inspect bed devices monthly. If the device has become loose/ unstable in any way it will be removed and the responsible party will be notified. 9. Two times per year the RN, or designee, will check the FDA website for recalls on bed assistive devices."	02310		

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02310	Continued From page 58 The Minnesota Department of Health (MDH) Assisted Living Resources and Frequently-Asked Questions (FAQs) website dated April 3, 2024, indicated the following documentation should be included in a resident's record related to consumer bed rails: -CPSC website should be reviewed regularly for updates on portable bed rail recalls; -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. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective July 23, 2024. Non-compliance remained and the scope and level remain unchanged.	02310		

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

Type: Full
Date: *07/23/24*
Time: 10:59:18
Report: 1021241194

Food and Beverage Establishment Inspection Report

Location:
The Kenwood
825 Summit Avenue
Minneapolis, MN55403
Hennepin County, 27

Establishment Info:
ID #: 0038350
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6123748100
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.

3-500E Microbial Control: time as a control

3-501.19B ***** Priority 1 *****

MN Rule 4626.0408B When using time only as a public health control for up to 4 hours, discard all TCS food that has been out of temperature control for more than 4 hours; was not at 41 degrees F (5 degrees C) or less when removed from temperature control; or is in unmarked containers.

ESTABLISHMENT WAS PLACING CONTAINERS OF MILK AND JUICE IN A METAL PAN ON TOP OF ANOTHER PAN FILLED WITH ICE. THE MILK AND JUICE WERE FOUND OUT OF TEMPERATURE CONTROL. STAFF ARE USING TIME AS A PUBLIC HEALTH CONTROL FOR THE MILK AND JUICE. SEE COMMENTS.

Comply By: 07/23/24

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

CHLORINE CONCENTRATION AT THE DISH MACHINE MEASURED 0PPM. THE DISH MACHINE WAS PRIMED A FEW TIMES DURING INSPECTION AND THE CONCENTRATION WAS FIXED TO 100PPM. CORRECTED ON-SITE. A FEW CHLORINE TEST STRIPS WERE LEFT ON-SITE.

Comply By: 07/23/24

4-300 Equipment Numbers and Capacities

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

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

TEST KIT ON-SITE FOR THE QUATERNARY AMMONIUM (QUAT) EXPIRED IN 2018. PROVIDE NEW TEST KIT. NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE IN THE DISH MACHINE. PROVIDE.

Comply By: 07/30/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE CONTAINS DRIED FOOD DEBRIS AND METAL SHAVINGS. STAFF SENT THE CAN OPENER TO THE DISH MACHINE DURING INSPECTION AND IT WAS CLEANED AND SANITIZED DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 07/23/24

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

OBSERVED STAFF WASH THEIR HANDS AND USE THEIR CLEAN HANDS TO CLOSE THE FAUCET HANDLES. DISCUSSED HANDWASHING WITH DIRECTOR. COMPLY WITH RULE ABOVE.

Comply By: 07/23/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET WIPING CLOTHS WERE FOUND STORED IN A COUPLE OF SOAP AND WATER BUCKETS IN THE KITCHEN. WET WIPING CLOTHS WERE MOVED TO THE SANI BUCKET. DISCUSSED WITH STAFF THAT ONCE THE WIPING CLOTHS ARE WET, THEY NEED TO BE STORED IN AN APPROVED SANITIZER SOLUTION.

Comply By: 07/23/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

THERE ARE A FEW PIPES IN THE DRY STOREAGE ROOM WITH POTENTIAL MOLD AND MOISTURE BUILD-UP AROUND THEIR COVERINGS. PLEASE REMOVE AND REPLACE PIPE COVERINGS TO PREVENT ANY CONTAMINATION OF FOOD.

Comply By: 08/23/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Chlorine: = 0PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISH MACHINE *CORRECTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: SCRAMBLED EGGS - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 159 Degrees Fahrenheit - Location: OATMEAL - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CUT MELON - EVEREST PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: CUT WATERMELON - EVEREST PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: LIQUID EGGS - EVEREST PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: COLESLAW - EVEREST PREP COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 161 Degrees Fahrenheit - Location: SAUSAGE LINKS - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - WALK-IN COOLER
Violation Issued: No

Type: Full
Date: *07/23/24*
Time: 10:59:18
Report: 1021241194
The Kenwood

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: COOKED PORK - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: POT ROAST - WALK-IN COOLER
Violation Issued: No

Process/Item: Cooking
Temperature: 205 Degrees Fahrenheit - Location: SOUP - STOVE
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH FOOD SERVICE DIRECTOR, THANH LE AND HEALTH REGULATION DIVISION NURSE EVALUATORS, DEDE HINNENDAEL AND TAMMY CARLSON.

CONTINUATION OF MN Rule 4626.0408B
PER CONVERSATION WITH DIRECTOR, THEY DISCARD THE MILK AND JUICE AFTER BREAKFAST. THE CONTAINERS SIT OUT FOR ABOUT 3 HOURS. IF STAFF ARE USING TIME AS A PUBLIC HEALTH CONTROL THEY NEED TO TIME STAMP THE CONTAINERS OF MILK AND JUICE. THEY ALSO NEED TO DISCARD THE MILK AND JUICE AFTER SERVICE. FACT SHEET SENT WITH 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 1021241194 of 07/23/24.

Certified Food Protection Manager: THANH T. LE

Certification Number: FM77192 Expires: 01/22/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
THANH LE
FOOD SERVICE DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us