Electronically Delivered

November 2, 2023

Licensee
Brookdale Inver Grove Heights
5891 Carmen Avenue
Inver Grove Heights, MN 55076

RE: Project Number(s) SL30627015

Dear Licensee:

On October 13, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 18, 2023, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30627	A. BUILDING: _____ B. WING _____	R 10/13/2023

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BROOKDALE INVER GROVE HEIGHTS	5891 CARMEN AVENUE INVER GROVE HEIGHTS, MN 55076

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30627015-1 On October 12, through October 13, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed August 18, 2023. At the time of the survey, there were 12 active residents receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by:	{0 110}		

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{0 110}	Continued From page 1 No further action required.	{0 110}		
{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: No further action required.	{0 480}		
{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 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	{0 650}		

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{0 650}	Continued From page 2 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	{0 730}		

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{0 730}	Continued From page 3 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	{0 730}		

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{0 730}	Continued From page 4 status. This MN Requirement is not met as evidenced by: No further action required.	{0 730}		
{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: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	{0 810}		

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{0 810}	Continued From page 5 (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: No further action required.	{0 810}		
{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 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including:	{01370}		

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{01370}	Continued From page 6 (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: No further action required.	{01370}		
{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	{01440}		

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{01440}	Continued From page 7 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: No further action required.	{01440}		
{01540} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to 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	{01540}		

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{01540}	Continued From page 8 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: No further action required.	{01540}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	{01730}		

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{01730}	Continued From page 9 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}		
{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: No further action required.	{01880}		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	{01910}		

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{01910}	Continued From page 10 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		

Electronically Delivered

September 21, 2023

Licensee
Brookdale Inver Grove Heights
5891 Carmen Avenue
Inver Grove Heights, MN 55076

RE: Project Number(s) SL30627015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The 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. The 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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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

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.

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: 651-281-9796

JMD

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30627015 On August 15, 2023, through August 18, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight (8) active residents, all of whom received services under the Assisted Living facility license. On August 16, 2023, at approximately 4:31 p.m., an immediate order was issued for 2310. On August 17, 2023, at approximately 11:31a.m., an immediate order was issued for 1290. Immediacy of orders 1290 and 2310 was removed by evaluation supervisor review on August 17, 2023, however noncompliance remains at a scope and level of G, respectively.	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 Provider. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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	30627	A. BUILDING: _____ B. WING _____	08/18/2023

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0 110	Continued From page 1	0 110		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LALD-D had a Residency Permit effective through November 6, 2023. However, LALD-D's license lacked an organization listed as the Director of Record with BELTSS. On August 15, 2023, at 11:20 a.m., the surveyor observed the BELTSS website with LALD-D, and LALD-D stated the Director of Record was not listed with BELTSS. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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 included document titled, Food and Beverage Establishment Inspection Report dated August 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 650	Continued From page 3	0 650		
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 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 interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-C). 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 problems are pervasive or	0 650		

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0 650	Continued From page 4 represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B began providing direct care services for the licensee on June 6, 2022. ULP-B's employee record did not contain a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. LPN-C LPN-C began providing direct care services for the licensee on May 13, 2023. LPN-C's employee record did not contain a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On August 18, at 10:30 a.m., licensed assisted living director (LALD)-D stated LPN-C's and ULP-B's employee records lacked a job description. LALD-D stated they believed previous turnover or gaps in leadership positions played a part in missing documentation within their staff files. LALD-C stated the licensee has policies and systems in place to ensure compliance with state regulations. The license's Orientation and Annual Training Requirements policy dated August 2021, indicated "All Staff/Associates - Orientation includes job description reviewed upon hire and during employment if it changes."	0 650		

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0 650	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-C).	0 660		

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0 660	Continued From page 6 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: The licensee's TB facility risk assessment dated July 12, 2023, indicated the facility was low risk for TB. ULP-B ULP-B began providing direct care services for the licensee on June 6, 2022. ULP-B's employee record lacked evidence of the following: - TB history and symptom screening; and - two-step TST or blood test. LPN-C LPN-C began providing direct care services for the licensee on May 13, 2023. LPN-C's employee record included a Baseline TB screening tool for Health Care Workers (HCWs), dated March 30, 2023. LPN-C's employee record lacked evidence of a two-step TST or blood test. On August 18, at 10:30 a.m., licensed assisted living director (LALD)-D stated LPN-C's and ULP-B's employee records lacked required content of TB history and symptom screening and	0 660		

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0 660	Continued From page 7 two-step TST or blood test. LALD-D stated "I do believe previous turnover and/or gaps in leadership positions played a part in missing documentation within our staff files. [The licensee] has policies and systems in place to ensure compliance with state regulations." The licensee's Tuberculosis Exposure Control Plan policy last revised August 2021, indicated "Baseline TB screening is required at the time of hire for all health care workers in Minnesota and must include all of the following: a. Assessing for current symptoms of active TB. b. Assessing TB history, and c. Testing for the presence of active or latent infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test (IGRA)". The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 730	Continued From page 8	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 9 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's record included a discharge summary for one of one discharged resident (R1). 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 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: R1 was admitted to the facility on November 18, 2022. R1's record lacked a discharge summary. The licensee's Discharge or Deceased Resident Roster dated August 15, 2023, indicated the licensee discharged R1 on May 2, 2023, to a transitional care unit (TCU) on May 2, 2023. On August 15, 2023, a 2:00 p.m., director of nursing (DON)-A stated R1 had no discharge	0 730		

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0 730	Continued From page 10 summary in the record. DON-A was not sure if a discharge summary was completed by previous nurse. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 11 The findings are: On August 17, 2023, approximately from 10:15 a.m. to 12:5 p.m., survey staff toured the facility with the maintenance staff (MS)-E. During the tour, survey staff observed the following: -The fire suppression system had a slow leak on a fitting. -The shower spray handle was detached from the shower hose in Resident Unit #19. -Incorrect low hazard-rated backflow devices (Watts 9D) were observed on the make-up water lines to the heating boilers where chemicals are introduced. The MS-E confirmed chemicals were introduced when inquired about the boilers. Where chemicals are introduced in boiler systems, a reduced pressure zone backflow preventer is required to protect the drinking water system from possible contamination. The findings were verbally and physically verified by the MS-E accompanying the tour. On August 17, 2023, at approximately 1:00 p.m., during the exit interview, the MS-E and the licensed assisted living director (LALD)-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 12 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 documentation review and interview, the licensee failed to provide the minimum required number of employee evacuation drills, the required minimum training, and complete contents on the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 13 This has the potential to directly affect the safety of residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2023, at approximately 12:30 p.m. survey staff reviewed the facility's fire safety and evacuation plan and related documentation. The review of the documentation and interview with the maintenance staff (MS)-E and the licensed assisted living director (LALD)-D at approximately 1:00 p.m. indicated the following: -The licensee failed to provide resident emergency fire protection procedures. Survey staff received an updated fire evacuation plan for employees (associates)dated June 2023, Item 7, states, "Residents are to shelter in place until associates or fire department instructs to evacuate to new location." In addition, the review of the facility's resident handbook did not include procedures for fire and similar emergencies. -The record review indicated that the licensee failed to comply with the minimum required employee evacuation drills for the year 2022. No drill records were available or provided for review for dates before October 26, 2022. -The record review indicated the licensee did not provide employee training on the facility's fire safety and evacuation for the year 2022. No employee training records were provided or	0 810		

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0 810	Continued From page 14 available for the year 2022. -The record review indicated that the licensee did not provide training for the year 2022 to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. No resident training records were provided or available for the year 2022. On August 17, 2023, at approximately 1:30 p.m., during the exit interview, the MS-E and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	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:	01290		

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01290	Continued From page 15 Based on observation, interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services for one of one employee (unlicensed personnel (ULP)-B) and a background study was affiliated to the licensee's health facility identification number (HFID) for one of one employee (licensed practical nurse (LPN)-C). This had the potential to affect all residents currently receiving services. This resulted in an immediate correction order on August 17, 2023, at 11:30 a.m. 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: ULP-B ULP-B had a hire date of June 6, 2022, and provided direct cares for residents of the licensee. . On August 16, 2023, at 9:00 a.m., surveyor observed unlicensed personnel (ULP)-B providing medication administration to residents. ULP-B's employee record lacked evidence a background study had been completed prior to ULP-B providing direct care and services to the licensee's residents. LPN-C	01290		

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01290	Continued From page 16 LPN-C had a hire date of May 13, 2023, and provided direct cares for residents of the licensee. LPN-C's employee record included a background study dated May 13,2023, affiliated another licensee's HFID 30683. LPN-C's employee record lacked evidence the licensee affiliated a background study for LPN-C under the licensee's HFID number. On August 17, at 10:20 a.m., licensed assisted living director (LALD)-D stated there was not a background study clearance form in ULP-B's employee file. LALD-D stated she is aware of the background study clearance letter requirement but was not aware ULP-B did not have a background study clearance. Also, LALD-D verified the licensee had not affiliated LPN-C's employee background to the licensee's HFID. The licensee's PL.3-003 Criminal Background Check Policy last revised December 2020, indicated "A criminal background check is completed prior to employment. New associates should be considered conditionally employed pending the result of a needed criminal or additional background investigation. An individual with a record of criminal activity may be denied employment if the circumstances of the conviction substantially relate to circumstances of the particular job or would make that individual unqualified for his/her job. [The licensee] is prohibited from hiring or employing, under any circumstances, any person convicted of certain classes of crimes." No further information was provided.	01290		

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01290	Continued From page 17 TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed by evaluation supervisor review on August 17, 2023, however noncompliance remains at a scope and level of G.	01290		
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 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,	01370		

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01370	Continued From page 18 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 and competency was completed for one of one employee (unlicensed personnel (ULP)-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: ULP-B had a hire date of June 6, 2022, and provided direct cares for residents of the licensee. ULP-B's employee file lacked documentation of training and competency evaluations for the following topics: - range of motioning and positioning; - maintenance of a clean and safe environment; - preparation of modified diets as ordered by a licensed health professional; and	01370		

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01370	Continued From page 19 - awareness of commonly used health technology equipment and assistive devices. On August 16, 2023, at 9:00 a.m., surveyor observed ULP-B providing medication administration to residents. On August 18,2023 at 10:30 a.m., licensed assistance living director (LALD)-D stated ULP-B's employee record lacked documentation of training and competency evaluation for the above topics, as required. LALD-D stated "For the staff training, I do believe previous turnover and/or gaps in leadership positions played a part in missing documentation within our staff files. [The licensee] has policies and systems in place to ensure compliance with state regulations." The licensee's Orientation and Annual Training Requirements policy revised August 2021, indicated "Training & competency evaluation of unlicensed staff/associate providing Assisted Living services will be conducted by a registered nurse or an additional qualified instructor with the registered nurse." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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	01440		

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01440	Continued From page 20 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 interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-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:	01440		

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01440	Continued From page 21 ULP-B had a hire date of June 6, 2022, and provided direct cares for residents of the licensee. ULP-B's employee record lacked documentation of direct supervision to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On August 18, 2023 at 10:40 a.m., licensed assistance living director (LALD)-D stated ULP-B's employee record lacked documentation of direct supervision completed by RN within 30 days of providing services to residents. LALD-D stated "For the staff training, I do believe previous turnover and/or gaps in leadership positions played a part in missing documentation within our staff files. [the licensee" has policies and systems in place to ensure compliance with state regulations." The licensee's Orientation and Annual Training Requirements policy revised August 2021, indicated "Training & competency evaluation of unlicensed staff/associate providing Assisted Living services will be conducted by a registered nurse". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at	01540		

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01540	Continued From page 22 least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to 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 interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-C). 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: ULP-B ULP-B had a hire date of June 6, 2022, and	01540		

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01540	Continued From page 23 provided direct cares for residents of the licensee. ULP-B's Relias (online training platform) transcript dated August 16, 2023, indicated ULP-B completed 5.50 hours of dementia care training within the past 14 months. ULP-B's employee record lacked evidence had completed the required eight (8) hours of dementia training on the specific dementia care topics within 80 working hours of the employment start date. LPN-C LPN-C had a hire date of May 13, 2023, and provided direct cares for residents of the licensee. LPN-C's Relias transcript dated August 16, 2023, indicated 4 hours of dementia care training completed April 13, 2023. LPN-C's employee record lacked evidence had completed the required eight (8) hours of dementia training on the specific dementia care topics within 80 working hours of the employment start date. On August 18, at 10:30 a.m., licensed assisted living director (LALD)-D stated LPN-C's and ULP-B's employee records lacked evidence had completed the required eight (8) hours of dementia training within 80 working hours of the employment start date. LALD-D stated "For the staff training, I do believe previous turnover and/or gaps in leadership positions played a part in missing documentation within our staff files. [The licensee] has policies and systems in place to ensure compliance with state regulations."	01540		

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01540	Continued From page 24 The licensee's Orientation and Annual Training Requirements policy revised August, 2021, indicated "Supervisors of direct care, direct care associates must have 8 hours within 160 working hours on required topics. Assisted living with dementia care must have 8 hours within 80 working hours of employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730		

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01730	Continued From page 25 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R2). 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 September 28, 2021, at approximately 9:30 a.m., R2 was observed taking medications form	01730		

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01730	Continued From page 26 unlicensed personnel (ULP)-B. R2's Self-Administration of Medications & Medication Review Form dated June 30, 2023, indicated R2 was receiving medication administration daily. R2's individual medication management plan lacked identification of medication management tasks that may be delegated to unlicensed personnel. On August 17, 2023, at 2:45 p.m., director of nursing (DON)-A acknowledged the required content was missing and stated it will be added to the resident's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
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 review, the licensee failed to monitor a medication refrigerator to maintain medications according to the manufacturer's directions. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 27 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 15, 2023, at 11:05 a.m., the surveyor, in the presence of licensed practical nurse (LPN)-C, observed the medication refrigerator lacked a thermometer and no temperature log for medication refrigerator. The medication refrigerator contained one unopened box of Novolog Flexpen 100 unit/milliliter (ml) Kwik-Pen (short acting insulin) pens, contained two unopen pens. The manufacturer's instructions for Novolog 70/30 insulin Flexpen dated April 28, 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog 70/30 to freeze. On August 15, 2023, at 11:15 a.m. LPN-C stated staff were supposed to check and monitor the medication refrigerator daily and enter the temperatures into the log to ensure the temperature was in the recommended range, however, she was unable to retrieve the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01910	Continued From page 28	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). 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 at a widespread scope (when	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30627	A. BUILDING: _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE INVER GROVE HEIGHTS	5891 CARMEN AVENUE INVER GROVE HEIGHTS, MN 55076

(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
01910	Continued From page 29 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's MN Discharge or Deceased Resident Roster dated August 15, 2023, indicated R1 was admitted to the facility on November 18, 2022, with diagnosis heart failure and diabetes. The licensee discharged R1 on May 2, 2023. R1's record lacked documentation of medication disposition upon discharge from facility. On August 15,2023 at 2:00 p.m., registered nurse (RN)-A acknowledged R1's record lacked evidence of documented disposition of medications upon discharge. DON-A was not sure if disposition of medication was completed by previous nurse. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
02310 SS=G	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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30627	A. BUILDING: _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE INVER GROVE HEIGHTS	5891 CARMEN AVENUE INVER GROVE HEIGHTS, MN 55076

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02310	Continued From page 30 review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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 August 16, 2023, at approximately 2:30 p.m., the surveyor observed R3 lying on her bed and R3's bed was equipped with two half hospital bedrails. The bedrails were in the raised position towards the head of the bed. The bedrails were not loose from left to right or back and forth bilaterally (both sides). R3 admitted on November 3, 2022, with diagnoses including hypertension and acute kidney failure. R3's Personal Service Assessment/Personal Service Plan (PSA/PSP Q & A) scheduled assessment date June 30, 2023, indicated R3 required assistance with toileting, shower, transfers, medication administration, and R3 utilized a wheelchair. R3's Service Plan dated July 21, 2023, indicated R3 received services including medication management and activities daily living (ADL).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30627	A. BUILDING: _____ B. WING _____	08/18/2023

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BROOKDALE INVER GROVE HEIGHTS	5891 CARMEN AVENUE INVER GROVE HEIGHTS, MN 55076

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02310	Continued From page 31 R3's medical record lacked documentation of a bedrail assessment, measurements, and education of the risks and benefits associated with the use of bedrails. On August 16, 2023, at approximately 2:45 p.m., director of nursing (DON)-A acknowledged bedrails are in place for R3. DON-A stated the hospital bed was provided by hospice, and the licensee did not provide bed rails. DON-A stated the licensee was not aware bedrails were in place for R3, therefore no assessment, measurements and education of the risks and benefits associated with the use of bedrails were completed for R3. The licensee's Bedside Mobility Aids-AL policy revised March 2020, indicated the following; 1. Full side rails and/or half side rails are not allowed. 2. Floor-to-ceiling transfer/super poles, overhead trapeze bars, halo safety devices or another bedside mobility aids may be used after the DDO/RVP/Designee and District or Regional Nurse/designee review and consult with the community. 3. All residents utilizing bedside mobility aids should have a Negotiated Risk Agreement (as permitted per state regulation), or other state required form completed, making sure all risks are fully disclosed in the resident record. 4. A physician/licensed prescriber order for the use of any bedside mobility aid should be obtained prior to its use. The physician/licensed prescriber must indicate that the bedside mobility aid is to be used for movement and positioning. 5. Specific instructions related to bedside mobility aids and their use should be documented on the resident's Service Plan, reviewed with the staff,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30627	A. BUILDING: _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE INVER GROVE HEIGHTS	5891 CARMEN AVENUE INVER GROVE HEIGHTS, MN 55076

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02310	Continued From page 32 and updated regularly per existing standards or upon a resident's change in condition. 6. Bedside mobility aids should be installed per manufacturer's guidelines. 7. Adjustments to bedside mobility aids should be made only after consultation with a licensed healthcare professional and according to manufacturer's guidelines. 8. A physical and/or occupational therapy evaluation should be considered as part of the resident's overall plan for mobility. 9. The use of bedside mobility aids should be reviewed at the time of the scheduled resident reevaluation or upon a change in condition. 10. If the resident is on hospice, and hospice is providing a bed, the bed and any bedside mobility aid used must comply with this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed by evaluation supervisor review on August 17, 2023, however noncompliance remains at a scope and level of G.	02310		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *08/15/23*
Time: 08:57:51
Report: 7963231075

Food and Beverage Establishment Inspection Report

Location:
Brookdale Inver Grove Heights
5891 Carmen Avenue
Inver Grove Heights, MN55076
Dakota County, 19

Establishment Info:
ID #: 0037956
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513060919
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

ESTABLISHMENT IS REQUIRED TO DOCUMENT ANY EMPLOYEE ILLNESS. NO ILLNESS LOG ON SITE. BLANK ILLNESS LOG SENT TO ESTABLISHMENT.

Comply By: 08/16/23

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER RINSE CYCLE ONLY REACHED 153 DEG F WHEN TESTED WITH A MIN/MAX WATERPROOF THERMOMETER. USE ALTERNATIVE METHODS TO SANITIZE DISHES AND UTENSILS UNTIL DISH MACHINE IS REPAIRED. REPAIR CALLED FOR BY ESTABLISHMENT.

Comply By: 08/15/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Hot Water: = at 153 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: TOMATO SAUCE
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: SOUR CREAM
Temperature: 35 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

THIS FOOD AND BEVERAGE INSPECTION WAS DONE AS PART OF A HEALTH REGULATIONS DIVISION SURVEY.

FOOD INSPECTION WAS COMPLETED WITH KITCHEN MANAGER LISA SANDERS AND RESULTS REVIEWED WITH HER AND LEAD SURVEYOR NURSE SAFIA HASSAN.

THE KITCHEN IS BUILT TO COMMERCIAL KITCHEN STANDARDS.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-PROPER SANITIZING OF DISHES AND UTENSILS
-VOMIT/FECAL CLEAN UP POLICY
-SANITIZER USE AND TESTING
-DATE MARKING, COOLING AND STORAGE OF FOOD

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 7963231075 of 08/15/23.

Certified Food Protection Manager Lisa Sanders

Certification Number: FM 56515 Expires: 05/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Lisa Sanders
PIC

Signed: Peggy Spadafore
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963231075

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/15/23
Time In 08:57:51
Time Out

Brookdale Inver Grove Heights	**Address** 5891 Carmen Avenue	**City/State** Inver Grove Heights, MN	**Zip Code** 55076	**Telephone** 6513060919
License/Permit # 0037956	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Surpervision			
1	IN OUT		
2	IN OUT N/A		
Employee Health			
3	IN OUT		
4	IN OUT		
5	IN OUT		
Good Hygenic Practices			
6	IN OUT N/O		
7	IN OUT N/O		
Preventing Contamination by Hands			
8	IN OUT N/O		
9	IN OUT N/A N/O		
10	IN OUT		
Approved Source			
11	IN OUT		
12	IN OUT N/A N/O		
13	IN OUT		
14	IN OUT N/A N/O		
Protection from Contamination			
15	IN OUT N/A N/O		
16	IN OUT N/A		
17	IN OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
19	IN OUT N/A N/O		
20	IN OUT N/A N/O		
21	IN OUT N/A N/O		
22	IN OUT N/A		
23	IN OUT N/A N/O		
24	IN OUT N/A N/O		
Consumer Advisory			
25	IN OUT N/A		
Highly Susceptible Populations			
26	IN OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
28	IN OUT		
Conformance with Approved Procedures			
29	IN OUT N/A		

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 08/16/23

Inspector (Signature) Peggy Spurley