Electronically Delivered

February 12, 2025

Licensee
Brookdale Plymouth
15855 22nd Avenue North
Plymouth, MN 55447

RE: Project Number(s) SL30690016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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.

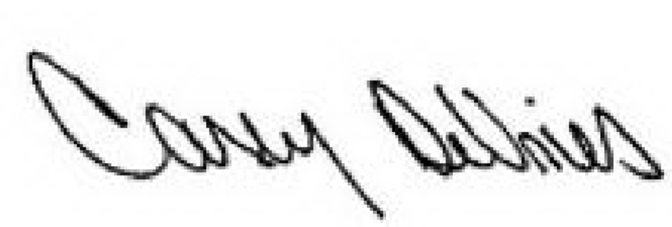
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	30690	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments 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: SL30690016-0 On January 6, 2024, 2024, through January 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 39 residents all of whom received services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (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 that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for two of three unlicensed personnel ((ULP)-A, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 510		

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0 510	Continued From page 4 The findings include: On January 7, 2025, at 7:14 a.m., the surveyor observed an unbagged urine saturated comforter and bedding on the floor. ULP-A was attempting to open the laundry room door to place items into the wash. On January 7, 2025, at 7:16 a.m., the surveyor observed ULP-A apply gloves, assist R1 to stand from the toilet, provide perineal care to R1, and remove gloves. Without performing hand hygiene, ULP-A applied a new pair of gloves, lifted R1's incontinent pull up and pants, assisted R1 to sit into the wheelchair, buttoned R1's sweater, and removed gloves. Without performing hand hygiene, ULP-A set up R1's toothbrush and instructed R1 on how to use it, placed towel over R1's clothing, and removed one glove. Without performing hand hygiene, ULP-A placed one new glove back onto their hand, assisted with washing, drying, and applying lotion to R1's face and removed gloves. Without performing hand hygiene, ULP-A brushed R1's hair, applied glasses and ChapStick to R1, assisted R1 to the dining room for breakfast in their wheelchair, located a clothing protector in a cabinet, and placed a clothing protector on R1. Without performing hand hygiene, at 7:30 a.m., the surveyor observed ULP-A enter R4's room. ULP-A offered clothing choices to R4, and assisted R4 with ambulation to the bathroom. ULP-A placed gloves to their hands, assisted R4 to sit on the toilet, removed socks, shoes, and soiled incontinent pull up. Without removing gloves or performing hand hygiene, ULP-A applied a clean incontinent pull up, pants, and shoes, removed night shirt, placed new shirt and sweater on R4 then removed their gloves. Without preforming hand hygiene, ULP-A applied	0 510		

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0 510	Continued From page 5 a new pair of gloves, assisted R4 to stand, and provided perineal care to R4. Without providing hand hygiene, ULP-A lifted R4's incontinent pull up and pants, straightened R4's shirt, assisted R4 to the bathroom sink, placed towel over R4's shirt, set up a toothbrush with toothpaste, and removed gloves. Without performing hand hygiene, ULP-A handed the toothbrush to R4 and encouraged them to brush their teeth, used a walkie talkie to call for assistance and a wheelchair due to R4's weakness. ULP-B brought in a wheelchair, ULP-A and ULP-B assisted R4 into the wheelchair, ULP-A placed a new set of gloves, assisted R4 with washing and drying their face, and removed gloves. Without performing hand hygiene, ULP-A assisted R4 with hair care, and pushed R4's wheelchair to the dining room. ULP-A walked back to R4's room to retrieve a walker and returned to the dining room. ULP-B and ULP-A assisted R4 to a standing position and guided R4 to sit into a dining room chair. ULP-A left the dining room with the wheelchair, entered and then exited a storage room to retrieved garbage bags, entered and exited a shower room to retrieve washcloths. At 8:18 a.m., without performing hand hygiene, ULP-A entered R6's room where ULP-E was placing a sling under R6 for a full body lift. ULP-A and ULP-E moved R6 to the wheelchair with the full body lift, and ULP-A washed their hands and left R6's room. During continuous observation, ULP-A did not perform hand hygiene between residents or between glove changes. On January 7, 2025, at 8:35 a.m., the surveyor observed ULP-E strip R10's bedding saturated with urine and place the bedding into the laundry basket then remove gloves. Without performing hand hygiene, ULP-E placed a new pair of gloves, guided R10 to the toilet, lowered R10's	0 510		

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0 510	Continued From page 6 pants, assisted R10 to sit on the toilet, removed soiled incontinent pull up, pants, and socks. R10 began to strike out at ULP-E. ULP-E applied a clean brief, socks, pants, and shoes to R10. ULP-E then attempted to change R10's shirt however, R10's combative behavior increased and R10 was unable to be redirected. R10 independently stood from the toilet and began to walk out of the room while ULP-E attempted to readjust R10's lower body clothing. ULP-E removed their gloves. Without performing hand hygiene, ULP-E exited R10's room with the laundry basket which contained multiple holes and laundry saturated with urine. ULP-E drug the laundry basket across the carpeted floor with use of a trash bag connected to the laundry basket and pulled it to the laundry room. Upon entering the laundry room, the surveyor observed at least four laundry baskets that had trash bags tied to them. ULP-E placed a new pair of gloves on, took laundry out of the dryer and placed them into a laundry basket, switched the clothing from the washer to the dryer, and then placed R10's bedding into the washer, and removed gloves. Without performing hand hygiene, ULP-E exited the laundry room, entered the dining room, retrieved clothing protectors, placed a clothing protector on a resident, and then washed their hands. On January 7, 2025, at 9:47 a.m., ULP-A stated they were trained by the nurse to perform hand hygiene with glove changes and before giving care to another resident. ULP-A stated the licensee provided a portable bottle of sanitizer they had to refill when it was empty. ULP-A stated they realized they forgot to perform hand hygiene when they provided cares and washed their hands as soon as they realized it. ULP-A stated they forgot their sanitizer in their locker. ULP-A	0 510		

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0 510	Continued From page 7 stated they believed the evening or overnight shift created the laundry basket with the trash bag attached to it to transport the soiled laundry. ULP-A stated they carried soiled linen out of the room by their hands because they did not want the clean items to be placed into a soiled laundry basket. ULP-A stated the licensee did not provide large enough bags to fit the soiled bedding in to transport them to the laundry room. On January 8, 2025, at 10:45 a.m., licensed practical nurse (LPN)-J stated ULP were trained to use sanitizer or wash their hands between glove changes, between soiled cares, before and after cares, prior to serving meals, when they arrive to work, and after using the restroom. LPN-J stated the licensee used a learning management system (LMS), provided onsite training, and complete tests related to infection control. LPN-J stated ULP must sanitize or wash their hands after they remove gloves. LPN-J stated the licensee's protocol was to bring soiled laundry to the laundry room with use of garbage bags, and staff were not trained nor were ULP allowed to drag laundry baskets on the floor. LPN-J stated the licensee provided large enough garbage bags to carry soil bedding to the laundry room. The CDC's Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated hand hygiene should be performed: - immediately before touching a resident; - before performing an aseptic tasks as placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same resident; - after touching resident or resident surroundings; - after contact with blood, body fluids, or	0 510		

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0 510	Continued From page 8 contaminated surfaces; and - immediately after glove removal. The licensee's Infection Control Plan dated May 2023 indicated contaminated laundry should be placed and transported in bags or containers labeled or color-coded. In addition, the policy read, " All associates should practice hand washing using the following guidelines. 1. Wash their hands immediately or as soon as practicable after the removal of gloves and/or other personal protective equipment. 2. Hands or other areas of skin should be washed immediately following contact with contaminated or other potentially infectious materials. 3. Flushing of mucous membranes (eyes) should occur immediately following contact with contaminated or other potentially infectious materials. 4. Associates should wash their hands between caring of residents. 5. Associates should follow the hand washing protocols found in the training manual for effective results. Antimicrobial Hand Gels 6. If soap, water, or towels are unavailable, the associate should use an antimicrobial hand gel according to manufacturer's guidelines. 7. Do not use alcohol-based hand rubs when hands are visibly soiled, contaminated with blood or other body fluids." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 9 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 6, 2025, at 3:12 p.m., during a facility tour the surveyor observed no 911 emergency number posted near a phone connected to the wall of the dining room. Licensed assisted living	0 640		

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0 640	Continued From page 10 director (LALD)-D stated the phone could be used by residents and visitors however, the person would have to dial an eight prior to dialing the telephone number to place an outgoing call. LALD-D stated all incoming calls were routed to the front desk and could be transferred to the telephone. LALD-D stated they were aware of the statute however, they did not think it applied to the licensee because all residents that resided at the facility had the diagnoses of dementia and the residents would need staff assistance to place an outgoing call. On January 8, 2024, at 10:06 a.m., LALD-D stated the facility provided two phones, one on each unit, for residents and visitors to use. LALD-D stated one of the phones had a protective cover over the top of the phone and the other one did not. LALD-D stated they were going to address the posting with their corporate office to see if the licensee should remove the phones from the units or post the sign. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 11 (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 three employees (unlicensed personnel (ULP)-A, 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 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-A and ULP-B were hired May 17, 2019, and February 17, 2014, respectively.	0 650		

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0 650	Continued From page 12 ULP-A and ULP-B's records both lacked annual reviews that identified areas of improvement needed and training needs from 2021, 2022, 2023, and 2024. On January 8, 2025, at 11:45 a.m., licensed assisted living director (LALD)-D stated the licensee had missed completing annual reviews for some employees, but was not aware of the specific employees that did not have their annual reviews completed. LALD-D stated they would need to audit all employee records to identify which employee annual reviews were not current and complete them. LALD-D stated the licensee missed some annual reviews due to the covid-19 pandemic and they did not audit charts once the covid-19 pandemic emergency ended. The licensee's Associate File policy dated December 2020, indicated each employee record would include an annual performance evaluation and actions taken to address any improvements needed. 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 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;	0 780		

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0 780	Continued From page 13 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code and Minnesota Rule 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 6. 2025, from approximately 4:02 p.m. to 5:42 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour, the surveyor observed the	0 780		

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0 780	Continued From page 14 following: A fire door located in hallway A was altered, with latching hardware removed and the fire rating information placard painted over. Fire doors must be maintained in proper working order by approved means. LALD-D indicated during survey they did not know how this work had occurred and understood that unapproved alterations may nullify the fire rating of the assembly and create an unsafe environment during emergency. Emergency lights in the art room did not function properly when tested. Emergency lights should illuminate when tested to simulate disconnection from facility power. These deficient conditions were visually verified by LALD-D accompanying on the tour and LALD-D stated they understood requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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0 970	Continued From page 15 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. 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: The licensee's blank Residency Agreement included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: "C. INDEMNIFICATION. You and/or your Legal Representative agree to indemnify and hold us and our affiliated entities harmless for any losses, damages, and other expenses brought against us and/or an affiliated entity or individual arising, directly or indirectly, from your alleged negligent acts and/or omissions and /or the alleged negligent acts and/or omissions of a third-party acting on your behalf." On January 8, 2025, at 10:24 a.m., licensed assisted living director (LALD)-D stated the document listed above was used for all residents who resided in the facility. LALD-D stated they were not aware of the statute. LALD-D stated they used the contract that was provided to them by the corporate office.	0 970		

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0 970	Continued From page 16 On January 9, 2025, at approximately 11:30 a.m., during the exit conference, regional director of clinical services (RDOCS)-F stated the corporate office removed the section listed above two weeks ago from the blank Residency Agreement template however, the licensee had not issued new contracts or provided and amendment of the contract but plan to do issue new contract to residents within the next few weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=D	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 a staff member 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 interview and record review, the	01290		

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01290	Continued From page 17 licensee failed to ensure a background study was submitted and a clearance received in affiliation with the licensee's current health facility identification number (HFID#) for two of 43 employees (director of maintenance (DOM)-K, unlicensed personnel ULP-L). 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: DOM-K DOM-K was hired on May 6, 2024, to oversee maintenance operations for the licensee. ULP-L ULP-L was hired May 22, 2023, to provide direct care services to residents. On January 8, 2025, at 8:27 a.m., the surveyor observed the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 (a web-based system used to submit background study requests) and observed the following: - DOM-K affiliated to HFID# 30691, a sister facility of the licensee. - ULP-J affiliated to HFID# 30691, a sister facility of the licensee. On January 8, 2025, at 9:59 a.m., licensed assisted living director (LALD)-D stated the licensee conducts two background studies one	01290		

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01290	Continued From page 18 federal background study and one with department of human services on each employee prior upon hire. LALD-D stated once clearance letters were received the employee could begin working. LALD-D stated the licensee affiliates each employee to the licensee's HFID#. LALD-D stated the employees listed above were transferred from a sister facility and the business office may have forgotten to affiliate the employees. On January 8, 2025, at 10:07 a.m., business office coordinator (BOC)-G stated human resources told them they did not need to affiliate transfers from sister facilities. BOC-G handed the surveyor an email dated August 14, 2024, from the licensee's corporate office that indicated new background checks and I-9 were not needed for transfers. The licensee's Criminal Background Check dated December 2020 indicated a criminal background check was completed prior to employment. The licensee's policy did not address the background study to be affiliated with the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=F	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	01470		

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01470	Continued From page 19 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care 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 staff member 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	01470		

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01470	Continued From page 20 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 interview and record review, the licensee failed to complete an orientation which included all required content for three of three employees (unlicensed personnel (ULP)-A, 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 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 1, 2021, the licensee converted from a housing with services (HWS) license and was issued an assisted living facility with dementia care (ALFDC) license. ULP-A ULP-A was hired on May 17, 2019.	01470		

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01470	Continued From page 21 ULP-A's Relias Transcript printed January 8, 2025, at 11:29 a.m., was identified by licensed assisted living director (LALD)-D as ULP-A's complete orientation training record with the oldest training date of February 23, 2021, prior to when the licensee converted to the current ALFDC license. The transcript lacked evidence ULP-A received orientation to the assisted living statutes when the licensee converted their license. ULP-B ULP-B was hired on February 17, 2014. ULP-B's Relias Transcript printed January 8, 2025, at 11:27 a.m., was identified by LALD-D as ULP-B's complete orientation training record with the oldest training date of December 22, 2020, prior to when the licensee converted to the current ALFDC license. The transcript lacked evidence ULP-B received orientation to the assisted living statutes when the licensee converted their license. LPN-C LPN-C was hired on December 19, 2019. LPN-C's Relias Transcript printed January 8, 2025, at 11:22 a.m., was identified by LALD-D as LPN-C's complete orientation training record with the oldest training date of March 9. 2021, prior to when the licensee converted to the current ALFDC license. The transcript lacked evidence LPN-C received orientation to the assisted living statutes when the licensee converted their license. On January 8, 2025, at 11:45 a.m., LALD-D stated the licensee failed to assign statute	01470		

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01470	Continued From page 22 training to all employees who were employees when the licensee converted their license. LALD-D stated licensee would need to audit the training records for each employee who was employed prior to converting the license, but employees hired after the conversion were provided the required orientation. The licensee's Orientation and Annual Training Requirements policy dated August 2021, indicated all employees would be orientated to an overview of the 144G (ALFDC) regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 23 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. 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 interview and record review, the	01500		

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01500	Continued From page 24 licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three 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 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-B ULP-B was hired on February 17, 2014. ULP-B's Relias Transcript printed January 8, 2025, at 11:27 a.m., was identified by licensed assisted living director (LALD)-D as ULP-B's complete annual training record. The transcript lacked evidence ULP-B received the following annual training: - reporting maltreatment of vulnerable adults; - assisted living bill of rights; - effective approaches to use with challenging residents who have dementia or related disorders; and - principles of person-centered planning and service delivery. LPN-C LPN-C was hired on December 19, 2019. LPN-C's Relias Transcript printed January 8,	01500		

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01500	Continued From page 25 2025, at 11:22 a.m., was identified by LALD-D as LPN-C's complete annual training record. The transcript lacked evidence ULP-B received the following annual training: - principles of person-centered planning and service delivery. On January 8, 2025, at 11:45 a.m., LALD-D stated the licensee failed to assign all required annual training within the licensee's electronic training program. LALD-D stated licensee would need to audit the training records for each employee and assign the missing required annual trainings. LALD-D stated licensee had failed to update the required annual training when the licensee converted from the previously held housing with service license to the current assisted living facility with dementia care license. The licensee's Orientation and Annual Training Requirements policy dated August 2021, accurately indicated all required annual training each employee would receive every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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	30690	A. BUILDING: _____ B. WING _____	01/09/2025

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01620	Continued From page 26 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for two of three residents (R1, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on July 17, 2024, and began receiving assisted living services.	01620		

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01620	Continued From page 27 R1's diagnosis included dementia, encephalopathy (a disease that affect brain structure or function that causes an altered mental state and confusion), hypertension, congestive heart failure, acute respiratory failure, chronic kidney disease stage 4, and repeated falls. R1's Service Plan signed August 7, 2024, indicated R1 received assistance with dressing, grooming, bathing, toileting, mobility, medication management, and skin care. R1's medical record included an admission assessment completed July 17, 2024, and a 14-day assessment dated August 5, 2024, 19 days after admission. R3 R3 admitted to the licensee on September 17, 2024, and began receiving assisted living services. R3's diagnosis included dementia, major depressive disorder, and abnormalities of gait and mobility. R3's Service Plan dated December 29, 2024, indicated R3 received assistance with dressing, grooming, bathing, toileting, mobility, and behavior management. R3's medical record included an admission assessment completed on September 17, 2024, and a 14-day assessment completed on October 6, 2024, 19 days after admission. On January 8, 2025, at 2:11 p.m., clinical nurse supervisor (CNS)-I, a clinical nurse supervisor	01620		

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01620	Continued From page 28 covering from a different licensee stated resident assessments were supposed to be completed upon admission, between day 14 and 30, and every 90 days unless a change of condition occurs. CNS-I stated they believed the 14-day assessment could be completed anytime between day 14 and day 30. The licensee's Service Plan template dated August 2022 indicated assessments would be completed by the registered nurse no later than 14 days after the initial assessment and ongoing assessments would be completed at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for three of 18 residents (R1, R7, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01890		

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01890	Continued From page 29 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 January 7, 2025, at approximately 11:21 a.m., the surveyor observed the licensee's medication cabinet and observed the following expired medications: - R1, one tube of diclofenac sodium topic gel with and expiration date of September 3, 2024; - R7, two bottles of nystatin powder 100,000 unit per gram (u/g) with an expiration date of September 30, 2023, one bottle of nystatin powder 100,000 u/g with an expiration date of August 31, 2023, four bottles of nystatin powder 100,000 u/g with and expiration date of November 20, 2024, one tube of clotrimazole vaginal cream 1 percent (%) with an expiration date of September 2023; and - R8, one bottle of Tylenol pain reliever 500 milligrams (mg) with an expiration date of July 2024 and one bottle of carbidopa-levodopa extended release (ER) 25 mg/100 mg with an expiration date of December 7, 2024. On January 7, 2025, at 11:52 a.m., unlicensed personnel (ULP)-B stated the nurses looked at the carts for expired medication daily. In addition, ULP-B stated if they noticed an expired medication they would alert the nurse for destruction of the medication. ULP-B stated they believed the medications listed above were discontinued orders. On January 8, 2025, at 10:51 a.m., licensed	01890		

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01890	Continued From page 30 practical nurse (LPN)-J stated they rely on the ULP passing the medication to remove discontinued medication. LPN-J stated they audit the medication carts for expired medications a couple times per month and when they receive a new cycle of medications from the pharmacy. LPN-J stated nurses were responsible for making sure the medication carts did not have expired medications however, the ULP who passed medications needed to ensure they were not administering expired medications. LPN-J stated they believed the medications were not removed from the medication cart due to having many medicated creams and powders in a small drawer however, the licensee just received a treatment cart to separate the medications from the medicated creams and lotions and they believed this would help with removing expired medicated powders and creams. The licensee's Unused Medication Disposal / Return to Resident/ Legally Responsible Party or Pharmacy policy dated March 1, 2023, indicated expired medication should be disposed of properly at the community within 30 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02090 SS=D	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training,	02090		

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02090	Continued From page 31 and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a dignified dining experience for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R5 admitted to the licensee on August 5, 2017, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021. R5's diagnoses included Alzheimer's and chronic pain. R5's Service Plan signed March 14, 2024, indicated R5 needed assistance with dressing, grooming, nutrition, bathing, toileting, mobility, and mechanical lift use. R5's ongoing assessment dated December 24, 2024, indicated staff assistance was needed to provide hand under hand/hand over hand assistance during meals for R5. On January 7, 2025, at approximately 8:50 a.m., the surveyor observed the secured care unit	02090		

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02090	Continued From page 32 (Clair) during breakfast. Unlicensed personnel (ULP)-F passed cold or hot cereal to residents. The surveyor observed all residents in the dining room eating with the exception of R5. At 9:06 a.m., approximately 10 minutes after R5 received their cereal, staff served a plate of food containing pancakes, bacon, and fruit and the plate was placed on top of R5's untouched cereal bowl. ULP-B, ULP-F, and licensed practical nurse (LPN)-C were completing tasks near or in the dining room and ULP-A was in a resident room assisting with cares. At 9:11 a.m., ULP-B administered medication to R5. ULP-A brought out an unknown resident and placed them next to R5. At 9:15 a.m., the surveyor observed five residents who finished their meal and nine residents who ate approximately 50 percent of their meal. ULP-A sat next to R5 19 minutes after food was first placed in front of R5 and began assisting them with feeding. On January 7, 2025, at 10:05 a.m., ULP-A stated R5 needed assistance with feeding. ULP-A stated they were "short of staff" on January 7, 2025. ULP-A stated they provided care to another resident and that was why R5 waited to eat. ULP-A stated they did not know how long food was in front of R5 prior to them assisting with feeding however, other staff should have assisted. ULP-A stated on occasion the nurses would assist with resident feeding. On January 8, 2025, at 10:57 a.m., LPN-J stated staff attempt to place all residents who need assistance with feeding at one table and one staff member would feed two people. LPN-J stated, "ideally once someone has food placed, they are fed." LPN-J stated the table with residents who required feeding should be given food last. LPN-J stated nurses would assist with meals if available	02090		

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02090	Continued From page 33 and the ULP who passed medication should assist during mealtime. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02090		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *01/06/25*
Time: 15:30:00
Report: 1051251004

Food and Beverage Establishment Inspection Report

Location:
Brookdale Plymouth
15855 22nd Avenue North
Plymouth, MN55447
Hennepin County, 27

Establishment Info:
ID #: 0037658
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634768200
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

AT TIME OF INSPECTION, THERE IS NO HIGH TEMPERATURE THERMOMETER OR THERMOLABEL STICKERS FOR THE DISHMACHINE.

Comply By: 01/13/25

Surface and Equipment Sanitizers

Acid: = 704 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: DISHMACHINE
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED PARMESIAN CHEESE
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 15:30:00
Report: 1051251004
Brookdale Plymouth

Food and Beverage Establishment Inspection Report

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

MET WITH NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE CULINARY DIRECTOR, SPENCER:

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051251004 of 01/06/25.

Certified Food Protection Manager: Christine M. Cabor

Certification Number: FM113554 Expires: 11/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Spencer
Culinary Director

Signed: Kai Yang

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us