Electronically Delivered

June 13, 2022

Administrator
Brookdale North Oaks
300 Village Center Drive
North Oaks, MN 55127

RE: Project Number(s) SL30692015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 6, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30692	A. BUILDING: _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL30692015 On, May 2, through May 6, 2022, 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 37 residents, all of whom recieved services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 May 2, 2022, 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 2	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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee record included all required content for one of two	0 650		

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0 650	Continued From page 3 unlicensed personnel ((ULP)-B) with employee records reviewed. 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 was hired on May 10, 2021. ULP-B's record lacked a Department of Human Services (DHS) background study. Although ULP-B's "mycertiphi.com" form dated July 21, 2021, indicated ULP-B's background had no findings of criminal history, the study was not completed by DHS as required. On May 4, 2022, at approximately 11:00 a.m., administrator (A)-D indicated all employees are required to have a DHS background study in their record and acknowledged ULP-B's DHS background study was not in their record. A-D indicated a background study was completed but was misplaced. A-D provided a DHS background study for all other employees but was unable to locate ULP-B's background study. The licensee did not provide a policy or procedure related to background checks. No further information provided. TIME PERIOD FOR CORRECTION:	0 650		

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0 650	Continued From page 4 Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms for all resident rooms throughout the facility. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 5 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 May 5, 2022, between the hours of 9:00 a.m. and 11:30 a.m., survey staff toured the facility with the regional maintenance technician (RMT)-F. During the tour, it was observed that each resident room throughout the facility was provided with a smoke detector, but the detector was not capable of providing an alarm to sound inside the room as required. The RMT-F verified the findings while on tour as he explained that the smoke detectors in the resident rooms will only detect smoke and will not alarm locally inside the resident rooms, but all smoke detectors were part of the facility's fire alarm system. He also added that smoke detectors out in the corridor were provided with fire alarm horn strobes that will alarm in the corridor as part of their fire alarm system. Survey staff explained that the assisted living law requires each sleeping room must be provided with a smoke alarm and that when it is actuated, it will provide an alarm sound inside the resident room to alert the resident. This affects all resident rooms. On May 5, 2022, at approximately 2:30 p.m., at the exit interview, survey staff explained when the smoke detector is actuated, the detector must provide an alarm in the resident room. The executive director-D and the RMT-F acknowledged the findings and asked for more details and acceptable options to achieve	0 780		

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0 780	Continued From page 6 compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment 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). The findings include:	0 800		

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0 800	Continued From page 7 On May 5, 2022, between the hours of 9:00 a.m. and 11:30 a.m., survey staff toured the facility with the regional maintenance technician (RMT)-F. During the tour, the following were observed: -The emergency lights in the art room were not working properly. -The 1-hour rated set of double doors for the furnace rooms located in exit corridors of building areas B and D did not latch when closed. On May 5, 2022, at approximately 2:30 p.m., the executive director-D and the RMT-F acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=D	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 8 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required documentation on employee training on fire safety and evacuation plans. This had the potential to directly affect the safety 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 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 May 5, 2022, at approximately 9:20 a.m., survey staff received the fire safety and evacuation documentation, evacuation drill, and	0 810		

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0 810	Continued From page 9 training documentation from the regional maintenance technician (RMT)-F for review. At approximately 1:00 p.m., the document review indicated the licensee lacked documentation and records for employee training specific to fire safety and evacuation plans to substantiate the minimum training frequency at least twice a year. The finding was verified with the RMT-F as he discussed about achieving compliance by editing their OSHA training schedule to incorporate fire safety and evacuation training. The RMT-F added that they typically hold an all-staff monthly meeting and can incorporate this training into that schedule. On May 5, 2022, at approximately 2:30 p.m., the executive director-D and the RMT-F acknowledged the finding at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 970 SS=F	144.50 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 10 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 2, 2022, at approximately 10:00 a.m., administrator (A)-D provided a blank Residency Agreement and indicated the document was the licensee's assisted living contract. R1, R2, and R3's Residency Agreements were signed September 27, 2021, August 31, 2021, and July 28, 2021, respectfully. Under section 6 Miscellaneous, part C, Risk Agreement, the Residency Agreement read, "You are responsible for your personal, financial and health care decisions. You are also responsible for maintaining health, personal property, liability, automobile (if applicable), and other insurance coverages in adequate amounts. You agree to obtain insurance in an amount adequate to cover your personal property and your general liability." This indicated a waiver of liability by the licensee for personal safety and property of the resident was included in the assisted living contract.	0 970		

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0 970	Continued From page 11 On May 4, 2022, at approximately 11:00 a.m., A-D acknowledged the language in the identified assisted living contracts for R1, R2, and R3, included a waiver of liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=F	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	01370		

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BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 12 licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel ((ULP)-B and ULP-C) to include all required content with records reviewed. 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 May 3, 2022, from 7:30 a.m. to 9:00 a.m., ULP-C provided medication administration to the licensee's residents. ULP-B was hired May 10, 2021. ULP-B's record lacked documentation to indicate	01370		

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01370	Continued From page 13 the employee completed training and/or practical skills evaluations as required. ULP-C was hired on September 1, 2021. ULP-C's record lacked documentation to indicate the employee completed training and/or practical skills evaluations as required. On May 4, 2022, at approximately 11:00 a.m., administrator (A)-D acknowledged ULP-B and ULP-C's record lacked documentation of the required training and competencies. A-D indicated ULP-B and ULP-C did complete the required training but the licensee's MN Direct Caregiver Orientation & Skills Checklist form with the evidence of training and competency was not completed and included in either employee's record. A-D stated a completed form would need to be included in ULP-B and ULP-C's record as evidence of completed training. The licensee's Orientation and Annual Training Requirements policy dated August 2021, indicated all required areas of training and competency would be completed and documentation of the training would be included in the employee records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 14 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel ((ULP)-B and ULP-C) to include all required content with records reviewed. 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 May 3, 2022, from 7:30 a.m. to 9:00 a.m., ULP-C provided medication administration to the licensee's residents. ULP-B was hired May 10, 2021.	01380		

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01380	Continued From page 15 ULP-B's record lacked documentation to indicate the employee completed training and/or practical skills evaluations as required. ULP-C was hired on September 1, 2021. ULP-C's record lacked documentation to indicate the employee completed training and/or practical skills evaluations as required. On May 4, 2022, at approximately 11:00 a.m., administrator (A)-D acknowledged ULP-B and ULP-C's record lacked documentation of the required training and competencies. A-D indicated ULP-B and ULP-C did complete the required training but the licensee's MN Direct Caregiver Orientation & Skills Checklist form with the evidence of training and competency was not completed and included in either employee's record. A-D stated a completed form would need to be included in ULP-B and ULP-C's record as evidence of completed training. The licensee's Orientation and Annual Training Requirements policy dated August 2021, indicated all required areas of training and competency would be completed and documentation of the training would be included in the employee records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 16 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted 30-day supervision for delegated tasks to unlicensed staff as required for one of two unlicensed personnel (ULP-C) with records reviewed. 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	01440		

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01440	Continued From page 17 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May XX, 2022 at xx:xxp.m., ULP-C provided cares and medication administration to licensee's clients. ULP-C was hired on September 1, 2021. On May 3, 2022, from 7:30 a.m. to 9:00 a.m., ULP-C provided medication administration to the licensee's residents. ULP-C's record lacked documentation of supervision of delegated tasks within 30 calendar days of being delegated medication administration and treatment tasks. On May 4, 2022, at approximately 11:40 a.m., director of nursing (DON)-B verified ULP-C's record lacked documentation of supervision of delegated tasks within 30 days of hire. DON-B was unsure if a supervision was completed for ULP-C but stated if the supervisory visit was completed for ULP-C, it would be in the employee record. The licensee's Associate Supervision/Delegation policy dated August 2021, indicated supervision of delegated tasks would be completed within 30 days of delegation and documentation of supervision would be included in the employee's records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for one of three residents (R3) with records reviewed. 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	01640		

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01640	Continued From page 19 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: R3 admitted to licensee's care on July 29, 2021. R3's Personal Service Plan dated February 11, 2022, indicated as R3's most current service plan by director of nursing (DON)-A, lacked a signature or authentication by the licensee or by the resident or resident's representative. On May 4, 2022, at approximately 10:00 a.m., DON-A acknowledged R3's service plan lacked authentication by the licensee or by the resident or resident's representative. DON-A stated the service plan should have included the required authentication and maintained in the resident's record. The licensee's Service Plan Process Policy dated August 2021, indicated the service plan should be authenticated by the licensee and resident or resident's representative and maintained in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 20 (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 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	01730		

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01730	Continued From page 21 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 record with the required content for one of three residents (R3) with records reviewed. 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 May 3, 2022, at approximately 7:00 a.m., unlicensed personnel (ULP)-B provided oral medications to R3. R3 admitted to licensee's care on July 29, 2021. R3's record lacked an individualized medication management record. On May 4, 2022, at approximately 10:00 a.m., director of nursing (DON)-A acknowledged R3's individualized medication management record was not completed as required. DON-A stated the licensee uses a medication management document for all residents, but R3's record lacked the proper document and would not have a medication management record.	01730		

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01730	Continued From page 22 The licensee was requested to provide a policy related to medication management record content but was unable to locate a specific policy for the contents of a medication management record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was administered as prescribed for one of three residents (R3) with records reviewed. 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	01760		

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01760	Continued From page 23	01760		

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 May 3, 2022, at 7:00 a.m., unlicensed personnel (ULP)-B, while providing medications to R3, attempted to provide R3 with an incorrect medication and failed to provide a medication as ordered when supply was present.

On May 3, 2022, at approximately 8:00 a.m., as ULP-B prepared medications for R3, the surveyor noted ULP-B had retrieved a melatonin 5 milligram (mg) tablet (a sleep aid medication) instead of a memantine 5 mg tablet (a cognition enhancing medication for treatment of dementia in those who suffer from Alzheimer's disease) as ordered and placed the melatonin in R3's medication cup. R3's medication administration record (MAR) dated May 2022, read, "melatonin tablet 5 mg give 1 tablet by mouth at bedtime," and was scheduled for 2000 or 8:00 p.m. R3's MAR also read, "memantine hcl tablet 5 mg give 1 tablet by mouth one time a day," and was scheduled for 0800 or 8:00 a.m. ULP-B proceeded with the medication preparation and noted that R3's MAR read, "thiamine HCl tablet 100 mg give 1 tablet by mouth one time a day for B1 deficiency," and was scheduled for 0800 or 8:00 a.m. ULP-B searched the medication cart and in the medication room for a backup supply. ULP-B stated they were unable to locate the medication and would reorder the medication.

On May 3, 2022, at 8:12 a.m., ULP-B documented thiamine as, "not avaliabli," [sic] and

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01760	Continued From page 24 did not provide the medication as ordered. ULP-B proceeded to pour water in a cup and grabbed all the medications in the medication cup and started to walk toward R3. The surveyor stopped ULP-B and stated they had a medication error and the surveyor pointed out the melatonin and memantine error. ULP-B removed the melatonin from the medication cup and dispensed the memantine as ordered. The surveyor reviewed R3's medications in the medication cart and located a medication bubble card labeled "vitamin B-1 100 mg tablet" with an orange "morning" label on the top of the card. On May 3, 2022, at approximately 10:00 a.m., director of nursing (DON)-A acknowledged ULP-B had nearly provided R3 the incorrect medication and the medication labeled vitamin B-1 should have been provided to R3 for the thiamine order. DON-A stated ULP-B should have known the difference between the two medication and the correct medication for the thiamine order as ULP-B had completed all medication administration trainings. DON-A indicated a different staff would be administrating medications immediately and ULP-B would not be allowed to provide any medications to residents until ULP-B had completed a remedial medication administration training. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 25 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications included the expiration date for time sensitive medications for two of two residents (R2, R5) with records reviewed. 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 May 3, 2022, at 8:40 a.m., the surveyor observed medication administration and reviewed of the locked medication cart on the assisted living with memory care unit was completed. The following was observed: -R2's Systane eye drops (lubricant) lacked a label which indicated the date the eye drops had been opened and when the eye drops would expire. -R5's terbinafine hydrochloride (HCL) 1% (antifungal cream) lacked a label which indicated the date the cream had been opened and when the cream would expire. -In addition, a tube of ketoconazole (antifungal cream) lacked a label which indicated the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30692	A. BUILDING: _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 26 resident name or the date the cream had been opened and when the cream would expire. The manufacturer's instructions for Systane eye drops dated April 2017, instructed to discard one month after opening. The manufacturer's 2022 instructions for terbinafine HCL instructed to discard after the expiration date on the box or tube. No date was found. The manufacturer's 2022 instructions for ketoconazole cream instructed to discard after the expiration date on the box or tube. No date was found. On May 4, 2022, at 11:40 a.m., director of nursing (DON)-B stated the unlicensed personnel who administer the medications are expected to date all multiuse medications when opened with an expiration date. The licensee's Medication & Treatment-Storage policy dated October 2018, indicated medications and treatments should be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions. State regulations are to be followed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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	30692	A. BUILDING: _____ B. WING _____	05/06/2022

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02040	Continued From page 27 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On May 5, 2022, between the hours of 9:00 a.m. and 11:30 a.m., survey staff toured the facility with the regional maintenance technician (RMT)-F.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30692	A. BUILDING: _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

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02040	Continued From page 28 On May 5, 2022, at approximately noon, survey staff review the documentation provided by the RMT-F. A review of the documentation indicated the licensee failed to perform and develop the HVA plan to identify hazard vulnerabilities and mitigations on and around the property. Survey staff explained to the RMT-F that an HVA plan must be developed to include potential hazard vulnerabilities such as potential resident elopement for the delayed egress doors, active exit-seeking residents who may follow a visitor through a secured door, access to chemicals in the laundry and housekeeping rooms where staff had failed to lock and/or close doors properly that were observed during the tour of the building, and the risks of the misuse of portable fire extinguishers throughout the facility that need to be assessed and mitigated. The finding was verified by the RMT-F as he stated he had not completed an HVA plan on and around this facility, and provided an example of an HVA plan from another facility he will work from. On May 5, 2022, at approximately 2:30 p.m., survey staff explained that the licensee must develop and implement the HVA plan. The executive director-D and the RMT-F acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30692	A. BUILDING: _____ B. WING _____	05/06/2022

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BROOKDALE NORTH OAKS	300 VILLAGE CENTER DRIVE NORTH OAKS, MN 55127

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02110	Continued From page 29 assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care provided the required policies and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 30 procedures for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked documentation the resident or resident's representative received the ten policies and procedures required to be provided at the time of move-in. On May 4, 2022, at approximately 10:00 a.m., administrator (A)-D and director of nursing (DON)-A acknowledged no documentation residents received the required ten policies and procedures would be in any resident's record. A-D stated the policies were created but the licensee was not aware they were required to be provided to the residents or resident's representatives at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *05/02/22*
Time: 13:00:00
Report: 1013221118

Food and Beverage Establishment Inspection Report

Location:
Brookdale North Oaks
300 Village Center Drive
North Oaks, MN55127
Ramsey County, 62

Establishment Info:
ID #: 0038200
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514828111
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.19CMN

MN Rule 4626.0780C Discontinue the use of a food preparation sink for anything other than food preparation.

ICE CUBES WERE DUMPED IN THE FOOD PREPARATION SINK LOCATED IN THE KITCHEN. STAFF IDENTIFIED THE SINK AS THE FOOD PREPARATION SINK. COMPLY WITH ABOVE RULE. DISCUSSED FOOD PREP SINK USE AND STAFF SANITIZED THE SINK.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-602.11D5

MN Rule 4626.0845D5 Clean equipment used for the storage of packaged or unpackaged food, such as a reach-in refrigerator, at a frequency which precludes accumulation of soil residues.

FOOD DEBRIS AND STICKY GRIME WERE INSIDE THE TALL COOLERS LOCATED IN THE BRIDGE AND CLARE PREP AREAS. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 05/02/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

FOOD DEBRIS WAS LOCATED INSIDE THE KITCHEN MICROWAVE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 05/02/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO HAND WASHING SIGN/POSTER WAS PROVIDED AT THE HAND WASHING SINKS LOCATED IN THE BRIDGE AND CLARE PREP AREAS. COMPLY WITH ABOVE RULE. MDH HAND WASHING POSTERS WERE EMAILED.

Comply By: 05/04/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.18

MN Rule 4626.1550 Clean all plumbing fixtures such as handwashing sinks, toilets, and urinals.

GRIME AND STICKY LIQUID WERE ON THE HAND WASHING SINKS LOCATED IN THE BRIDGE AND CLARE PREP AREAS. CLEAN, MAINTAIN CLEAN, AND USE ONLY FOR HAND WASHING. COMPLY WITH ABOVE RULE.

Comply By: 05/02/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Kitchen
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Mashed potatoes
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Ground beef
Temperature: 35 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Chopped lettuce
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Bridge area tall cooler
Violation Issued: No

Process/Item: Pie
Temperature: 40 Degrees Fahrenheit - Location: Clare area tall cooler
Violation Issued: No

Process/Item: Potatoes
Temperature: 10 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	5

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator B. Mueller.

Discussed final cook temperatures, cleaning, ware washing, temperature control, staff illness policy, hand washing, serving highly susceptible population, sanitizer use, and food handling procedures.

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 1013221118 of 05/02/22.

Certified Food Protection Manager: Kimberly Currier

Certification Number: 1880 Expires: 02/09/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kimberly Currier
Operator

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us