Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 10, 2025

Licensee
Assured Care
9630 Upton Road
Bloomington, MN 55431

RE: License Number 416441
Health Facility Identification Number (HFID) 32366
Project Number(s) SL32366015

Dear Licensee:

On December 19, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed December 19, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 19, 2024.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 20, 2024

Licensee
Assured Care
9630 Upton Road
Bloomington, MN 55431

RE: Conditional License Number 416441
Health Facility Identification Number (HFID) 32366
Project Number(s) SL32366015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 1, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 18, 2025**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 27, 2024, found not corrected at the time of the October 1, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0640-Posting Information For Reporting Suspected C-144g.42 Subd. 7 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10- $500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)- $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)- $500.00
0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 1, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $5,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

IMPOSITION OF FINES:

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.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Assured Care a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Assured Care is in substantial compliance.

a. **Health Facility Construction Permit:** Assured Care will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. **Within 21-days from the date of this notice, Assured Care will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.**

b. **General Contractor:** Assured Care must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within 21-days of the date of this notice:**

   i. Name

   ii. License Number

   iii. Contact Information

c. **Egress Window Requirements:** Assured Care will replace at least one window in occupied sleeping room two and four, and unoccupied sleeping room three, meeting the minimum size requirements.

   i. Must have minimum openable width of no less than 20 inches.
   ii. Must have minimum openable height of no less than 20 inches.
   iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
   v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Assured Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Assured Care is in substantial compliance on the follow up survey, MDH will remove the conditions from Assured Care's assisted living facility license, and Assured Care will correct any outstanding violations identified during the . If Assured Care is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32366	A. BUILDING: _____ B. WING _____	R 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	9630 UPTON ROAD BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32366015-1 On September 30, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 27, 2024. At the time of the survey, there were 2 active residents; 2 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 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: (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: Not reviewed during this survey.	{0 480}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c 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 and interview, the licensee failed to support protection and safety by not posting information and phone numbers for 911 emergency number as required. 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	{0 640}		

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{0 640}	Continued From page 2 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 June 24, 2024, at 1:04 p.m. during a facility tour with unlicensed personnel (ULP)-C, the surveyor observed there was no posting information and phone numbers for 911 emergency number by telephones as required. On June 24, 2024 at 1:28 p.m. licensed assisted living director (LALD)-A stated there was no posted 911 on or near the phones and maybe the posting had fallen down. On September 30, 2024 at 1:00 p.m., registered nurse (RN)-K stated there was no posted 911 emergency number on or near the phones and there had never been one posted. No further information was provided.	{0 640}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	{0 680}		

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{0 680}	Continued From page 3 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. 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) 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: The licensee's emergency preparedness plan May 24, 2022, lacked evidence of the following required content: - establishment of the emergency program that	{0 680}		

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{0 680}	Continued From page 4 describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - arrangements/contracts to re-establish utility services; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures based on the EP, risk assessment and communication plan; - Policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - Policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development	{0 680}		

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{0 680}	Continued From page 5 of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles; and - emergency prep testing requirements. - Missing Resident Policy dated May 24, 2022, failed to be reviewed twice a year as required. On June 27, 2024, at 1:40 p.m. licensed assisted	{0 680}		

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{0 680}	Continued From page 6 living director (LALD)-A stated all information for emergency preparedness was in the licensee's emergency preparedness binder and she was unaware the emergency preparedness plan did not have all the required content. On September 30, 2024, at 12:55 p.m. unlicensed personnel (ULP)-C stated she was unable to locate the EPP binder in the kitchen. ULP-C spoke with LALD-B and they looked in the office and around the facility and could not locate the binder. ULP-C stated she had not seen the binder in months. On September 30, 2024, at 1:00 p.m. registered nurse (RN)-K stated she was unable to find the emergency preparedness binder where is was supposed to be kept in the kitchen. RN-K called LALD-A and they did not know where the binder was at this time. RN-A stated this binder had not been updated since the last survey and they did not know how long it had been missing. No additional information was provided.	{0 680}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}		

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{0 700}	Continued From page 7 Not reviewed during this survey.	{0 700}		
{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 inside all sleeping rooms and interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.	{0 780}		

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{0 780}	Continued From page 8 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 a facility tour on June 25, 2024, at 3:15 p.m., with licensed assisted living director (LALD)-B, surveyor observed smoke alarms were not inside resident sleeping room one, located on the main floor. Upon testing alarms were not interconnected so activation of one alarm activates all alarms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour, LALD-B verified smoke alarms were not installed in resident room one. On September 30, 2024, at 1:05 p.m. during the facility tour surveyor noted there was not a smoke alarm in sleeping room one, and all alarms were not interconnected with activation of one alarm, sounding them all. On September 30, 2024, at 1:10 p.m. registered nurse (RN)-K stated the smoke alarms remained unchanged. Licensee had not added another smoke alarm in sleeping room one, and the remainer of the alarms were not interconnected. TIME PERIOD FOR CORRECTION: Two (2)	{0 780}		

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{0 780}	Continued From page 9 days.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on June 25, 2024, at 3:15 p.m., the surveyor observed the fire evacuation diagram posted on the main floor did not show the location and number of sleeping rooms. During same tour the surveyor observed that fire evacuation diagrams were not posted on the lower level of the facility. On June 25, 2024, at 4:30 p.m., licensed assisted living director (LALD)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee's FSEP, titled "Fire Safety", dated April 7, 2022, failed to include the following: The FSEP did not include an evacuation map with a floor plan that showed the location and number of resident sleeping rooms.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32366	A. BUILDING: _____ B. WING _____	R 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 810}	Continued From page 11 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. LALD-B left the facility prior to the surveyor completing documentation review. Survey staff conducted a phone interview on June 28, 2024, at 1:30 p.m. with licensed assisted living director (LALD-A). During interview survey staff explained to LALD-A the areas of the policy that were deficient. LALD-A stated they understood the requirements and would work on updating the policy and evacuation map. On September 30, 2024, at 12:40 p.m. during facility tour surveyor noted room numbers were not located on or near each room to identify clearly what room was associated to what number. On September 30, 2024, at 12:40 p.m. unlicensed personnel (ULP)-C stated she did not know what room was identified as room one. Surveyor asked to be taken to room one and ULP-C was not able to do that, even while looking at the floor plan. ULP-C stated the floor plan had been placed on the wall but there was no education to the staff related to the updates and changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 810}		

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{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 25, 2024, at 3:15 p.m. with licensed assisted living director (LALD-B), it was observed that compliant emergency escape	{0 820}		

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{0 820}	Continued From page 13 and rescue openings were not provided in resident sleeping rooms two and four. Occupied Resident Rooms: Resident sleeping room two, located on the main floor, occupied by R-3 emergency escape and rescue clear window opening measurements are 17 1/2 inches wide, 36 inches in height and 630 square inches in openable area. The window was measured with LALD-B, and survey staff present. The window did not meet the minimum requirements for clear opening width and clear opening area. Resident sleeping room four, located on the lower level, occupied by R-2 emergency escape and rescue clear window opening measurements are 26 1/2 inches wide, 20 inches in height and 530 square inches in openable area. The window was measured with LALD-B, and survey staff present. The window did not meet the minimum requirements for clear opening area. Unoccupied Resident Rooms: Resident sleeping room three, located on the main floor emergency escape and rescue clear window opening measurements are 18 inches wide, 36 inches in height and 648 square inches in openable area. The window was measured with LALD-B, and survey staff present. The window did not meet the minimum requirements for clear opening width. It was explained to LALD-B that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum	{0 820}		

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{0 820}	Continued From page 14 dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. On September 30, 2024, at 10:45 a.m. LALD-A stated the new replacement windows had not been installed yet due to waiting on contractors' availability. The windows had been purchased but licensee was not able to secure a date and time for the contractor to replace the windows. LALD-A acknowledged she understood this tag would be re-issued.	{0 820}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}		

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Electronically Delivered

August 1, 2024

Licensee
Assured Care
9630 Upton Road
Bloomington, MN 55431

RE: Project Number(s) SL32366015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 27, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32366	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	9630 UPTON ROAD BLOOMINGTON, MN 55431

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32366015 On June 24, 2024, through June 27, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on June 25, 2024, issued for SL32366015-0, tag identification 1290 at a level 3/Widespread (I). The immediacy was not removed prior to survey exit. An immediate correction order was identified on June 26, 2024, issued for SL32366015-0, tag identification 2310 at a level 3/Widespread (I). The immediacy was not removed prior to survey	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 exit. An immediate correction order was identified on June 25, 2024, issued for SL32366015-0, tag identification 0820. On June 27, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470		

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0 470	Continued From page 2 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required. In addition, the licensee failed to ensure the staffing plan was evaluated twice a year to ensure appropriate staffing levels. 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 June 24, 2024, at 12:53 p.m. during a facility tour with unlicensed personnel (ULP)-C, no daily staff schedule posting was observed by the surveyor. ULP-C stated there was no daily staff schedule posting. On June 24, 2024 at 1:22 p.m. licensed assisted living director (LALD)-A stated typically the staff schedule was up but it might have fallen down. The licensee lacked a daily staffing schedule that was posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.	0 470		

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0 470	Continued From page 3 The licensee's Direct Care Staffing Plan dated January 10, 2024, identified the following: · There will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs; Requirements for staff are available in the staffing policy. · Between the hours of 10:00 p.m. and 6:00 a.m. there will be direct-care staff able to respond to a resident's request for assitance with health and safety needs within a reasonable amount of time. These staff will be located in the home in order to respond within a reasonable amount of lime. · Adequate number of staff is determined by factors such as assessment, patient acuity, service requirements, and regulatory guidelines. · Staffing schedules and daily postings will reflect the determination of what is needed for an adequate number of staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 24, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	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 infection control program that	0 510		

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0 510	Continued From page 5 complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene by two of two unlicensed personnel (ULP-J, ULP-G). 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 June 26, 2024, during continuous observation, unlicensed personnel (ULP)-J was observed doing the following tasks: - 8:26 a.m. ULP-J began preparing R3's medications for administration. ULP-J was wearing gloves, and placed a clean paper towel on the work surface. ULP-J punched medications that could be crushed into a medication cup and punched medications that could not be crushed into her hand and placed them on the paper towel. ULP-J used a pill crusher to crush medications, added apple sauce to the cup, picked up the medications that were on the paper towel and placed them into the med cup. ULP-J then brought the medications to R3 and gave them to her to take. ULP-J did not remove gloves, wash hands, or use hand sanitizer after administration. - ULP-J began setting up R2's medication, wearing the same gloves. ULP-J followed the same process, punching medications that could be crushed into a medication cup and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 6 medications that could not be crushed into her hand and placed on the paper towel. ULP-J crushed medications, added applesauce, then picked up a capsule, opened the capsule and put the contents in the med cup, picked up another non-crushable medication and placed it in the medication cup. ULP-J then spooned the medications into R2's mouth to administer them. ULP-J failed to remove gloves, wash hands or use hand sanitizer. ULP-J removed the dirty dishes from the the table, locked some medications back into the cupboard, and documented medication administration. - 8:45 a.m. ULP-J was still wearing the same gloves, went into the living room area, picked up a TV remote and turned the TV on. ULP-J removed more of the dirty dishes from the dining table and brought them to the kitchen. ULP-J failed to change gloves, or complete hand hygiene and asked R2 if she could administer his eye drops. ULP-J administered the eye drops to R2, touching his face to pull the eye lid down during the procedure and dabbing his eyes with a tissue after eye drops were administered. ULP-J finished clearing the kitchen table, unlocked the medication cupboard and locked up the eye drops, then removed gloves and washed her hands. On June 27, 2024, during continuous observation, ULP-G was observed doing the following tasks: - 8:15 a.m. ULP-G put on gloves and began setting up medications for R2. ULP-G crushed the medications that could be crushed and then added the medications that could not be crushed. ULP-G administered the oral medications to R2. ULP-G cleared dirty dishes from the dining room table. With the same gloves, ULP-G administered eye drops to R2.	0 510		

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	32366	A. BUILDING: _____ B. WING _____	06/27/2024

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0 510	Continued From page 7 On June 27, 2024, at 1:33 p.m. licensed assisted living director (LALD)-A stated staff should be changing gloves and completing hand hygiene between residents and prior to administration of eye drops. The licensee's Infection Control policy dated April 7, 2024, identified "Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between resident contacts, and when indicated to prevent transfer of microorganisms between resident or the environment." 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 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:	0 640		

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0 640	Continued From page 8 Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. 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 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 June 24, 2024, at 1:04 p.m. during a facility tour with unlicensed personnel (ULP)-C, the surveyor observed there was no posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number in common areas and by telephones as required. On June 24, 2024 at 1:28 p.m. licensed assisted living director (LALD)-A stated there was no MAARC posting or 911 on or near the phones and maybe the posting had fallen down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 650	Continued From page 9	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-C, ULP-D, and ULP-J). 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	0 650		

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0 650	Continued From page 10 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 June 24, 2024, at 12:58 p.m. during a facility tour with ULP-C, a stair lift was noted on the stairs in the home. ULP-C stated the lift was used to assist R2 up and down the stairs as he has a downstairs bedroom. On June 25, 2024, at 9:01 a.m. ULP-D was observed assisting R2 with dressing and grooming. ULP-D then assisted R2 to the stairway, assisted him to sit correctly on the stair lift, fastened the safety belt, and instructed him to push the button to bring the lift up the stairs. When R2 arrived at the top of the stairs, ULP-D assisted him out of the chair and to the dining room table. ULP-D stated a registered nurse (RN) had trained them how to use the stair lift. On June 26, 2024, at 7:45 a.m. ULP-J was observed assisting R2 up the stairs with the chair lift. On June 26, 2024, at 1:30 p.m. ULP-J stated an RN trained her how to use the stair lift. ULP-C, ULP-D, and ULP-J's employee files lacked documentation the staff had been trained and competency tested on the chair lift. On June 26, 2024, at 2:40 p.m. licensed assisted living director (LALD)-A stated the previous RN that no longer worked for the licensee, had trained and competency tested all staff on the chair lift but had not documented it; therefore,	0 650		

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0 650	Continued From page 11 there was no record of it in the employee files. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed	0 660		

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0 660	Continued From page 12 personnel (ULP)-C). This had the potential to affect all residents and staff of the facility. 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: ULP-C's personnel file identified she was hired on February 13, 2024. ULP-C's file did not include a TB health history and symptom screen or a TB test. On June 27, 2024, licensed assisted living director (LALD)-A stated there was no screening or testing for TB in ULP-C's record and it should have been completed. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated June 13, 2024, identified baseline TB screening was completed on all staff at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB	0 660		

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0 660	Continued From page 13 screening should be documented in the employee's record." "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 14 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. 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) 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: The licensee's emergency preparedness plan May 24, 2022, lacked evidence of the following required content: - establishment of the emergency program that describes the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster; - arrangements/contracts to re-establish utility services; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - policies and procedures based on the EP, risk assessment and communication plan;	0 680		

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0 680	Continued From page 15 - Policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - Policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - policy and procedure for system to track the location of on-duty staff and sheltered residents; - policy and procedure to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure that address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address role of facility under a waiver declared by the Secretary; - communication plan that included all the following names/contact information: staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - communication plan that included information	0 680		

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0 680	Continued From page 16 for Federal, State, tribal, regional and local EP staff; state licensing and certification agency; - communication plan that included primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies; - communication plan that included a method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii); - communication plan that included a means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction; - communication plan that included a method for sharing information EP with residents and their families/representatives; - emergency plan training and testing program; - policy and procedure for initial training in emergency program to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected roles; and - emergency prep testing requirements. - Missing Resident Policy dated May 24, 2022, failed to be reviewed twice a year as required. On June 27, 2024, at 1:40 p.m. licensed assisted living director (LALD)-A stated all information for emergency preparedness was in the licensee's emergency preparedness binder and she was unaware the emergency preparedness plan did not have all the required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 700	Continued From page 17	0 700		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. 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 June 27, 2024, at 8:05 a.m. unlicensed personnel (ULP)-G set medications on a desk next to an open laptop with R3's medication administration record (MAR) open and visible to all. ULP-G went into the dining room and assisted R2 to ambulate from the dining room, passed the desk with the laptop, to the living room area. ULP-G went to lock up R3's medications in the kitchen, washed hands and put on gloves, the laptop was not within his sight but was still open	0 700		

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0 700	Continued From page 18 to R3's (MAR). ULP-G set up R2's medications, left the desk area with the laptop open and visible to all with R2's MAR. ULP-G went to the kitchen to get applesauce, went to the living room to administer R2's medications and returned to the kitchen to put dirty dishes in the sink. ULP-G then went to the living room, administered eye drops and returned to the desk to document. Throughout the observation, the laptop remained open and visible to all residents, staff, and visitors that may have been in the building with residents' confidential health information on the screen. On June 27, 2024, at 1:35 p.m. licensed assisted living director (LALD)-A stated staff should close the laptop when they walk away from it to protect resident information. The licensee's Clinical Records policy dated April 7, 2024, identified "The records will be protected against loss, tampering or unauthorized disclosure and stored in a locked, secured location accessible to employees and contractors authorized to access the records." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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:	0 780		

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0 780	Continued From page 19 (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 inside all sleeping rooms and interconnected smoke alarms throughout the facility. 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 a facility tour on June 25, 2024, at 3:15 p.m.,	0 780		

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0 780	Continued From page 20 with licensed assisted living director (LALD)-B, it was observed that smoke alarms located inside resident sleeping rooms two and three located on the main floor, resident sleeping room four located in the basement, and smoke alarms located outside in the immediate vicinity of resident sleeping rooms were not interconnected so activation of one alarm activates all alarms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour, the smoke alarms were tested and LALD-B, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. On the same tour, it was also observed that smoke alarms were not provided inside resident sleeping room one, located on the main floor. Smoke alarms are required to be installed inside all resident sleeping rooms. During the tour, LALD-B verified smoke alarms were not installed in resident room one. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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	32366	A. BUILDING: _____ B. WING _____	06/27/2024

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0 790	Continued From page 21 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 a facility tour on June 25, 2024, at 3:15 p.m., with licensed assisted living director (LALD)-B, it was observed that the fire extinguisher located in the kitchen was labeled as B:C size 1 and had a date stamped on the bottom of 2017. This extinguisher did not meet the minimum size requirement of 2-A:10-B:C rating and lacked tags or documentation that indicated annual testing and monthly inspections had been conducted.	0 790		

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0 790	Continued From page 22 It was observed that there were no fire extinguishers provided in the lower level of the facility. Portable fire extinguishers are required to be provided in locations so that travel distance to the nearest fire extinguisher does not exceed 75 feet. LALD-B verified that there were no extinguishers in the lower level, and stated they understood the requirement. It was observed that two portable fire extinguishers were stored inside a closet by the kitchen and were not mounted as required. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. These extinguishers lacked tags or documentation that indicated annual testing and monthly inspections had been conducted. During the tour at the time of discovery, survey staff explained to LALD-B that the portable fire extinguishers must be properly mounted, meet the minimum size rating, and be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-B verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 23 (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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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, 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). Findings include: On a facility tour on June 25, 2024, at 3:15 p.m., with licensed assisted living director (LALD)-B the following was observed: It was observed that resident room two located on the main floor had an electrical box without a cover on the wall under the window. There were wires with wire nuts inside the box. Electrical boxes must have approved covers so wires are not exposed to the occupants of the room	0 800		

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0 800	Continued From page 24 creating the potential for electrical shock. It was observed that the door in resident sleeping room four located in the basement was broken at the bottom and had holes in it. It was observed that the elevated deck adjacent to the main floor living room had floor boards that were rotten. Deck floors must be maintained so they do not create a hazard that occupants could step or fall through. LALD-B verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 25 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on June 25, 2024, at 3:15 p.m., the surveyor observed the fire evacuation diagram posted on the main floor did not show the location and number of sleeping rooms. During same tour the surveyor observed that fire	0 810		

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0 810	Continued From page 26 evacuation diagrams were not posted on the lower level of the facility. On June 25, 2024, at 4:30 p.m., licensed assisted living director (LALD)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee's FSEP, titled "Fire Safety", dated April 7, 2022, failed to include the following: The FSEP did not include an evacuation map with a floor plan that showed the location and number of resident sleeping rooms. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as manual fire alarms. The policy had a section that stated where portable fire extinguishers were located but the section was not completed and updated for the facility. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems stated in the policy. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The plan included instructions to evacuate residents but did not include any	0 810		

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0 810	Continued From page 27 procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. LALD-B left the facility prior to the surveyor completing documentation review. Survey staff conducted a phone interview on June 28, 2024, at 1:30 p.m. with licensed assisted living director (LALD-A). During interview survey staff explained to LALD-A the areas of the policy that were deficient. LALD-A stated they understood the requirements and would work on updating the policy and evacuation map. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 28 Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 25, 2024, at 3:15 p.m. with licensed assisted living director (LALD-B), it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms two and four. Occupied Resident Rooms: Resident sleeping room two, located on the main floor, occupied by R-3 emergency escape and rescue clear window opening measurements are 17 1/2 inches wide, 36 inches in height and 630 square inches in openable area. The window was measured with LALD-B, and survey staff present. The window did not meet the minimum requirements for clear opening width and clear opening area. Resident sleeping room four, located on the lower level, occupied by R-2 emergency escape and rescue clear window opening measurements are 26 1/2 inches wide, 20 inches in height and 530 square inches in openable area. The window was measured with LALD-B, and survey staff present.	0 820	This immediate correction order identified on June 25, 2024, has had the immediacy lifted as of June 27, 2024 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 29 The window did not meet the minimum requirements for clear opening area. Unoccupied Resident Rooms: Resident sleeping room three, located on the main floor emergency escape and rescue clear window opening measurements are 18 inches wide, 36 inches in height and 648 square inches in openable area. The window was measured with LALD-B, and survey staff present. The window did not meet the minimum requirements for clear opening width. It was explained to LALD-B that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by LALD-B accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. On June 27, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited	0 970		

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0 970	Continued From page 30 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: 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 health, safety, or personal property for two of two residents (R2, R3). 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: R2 R2 was admitted on April 27, 2021, under the licensee's Comprehensive Home Care license and began receiving services under the licensee's Assisted Living license on August 1, 2021. R3 R3 was admitted on December 31, 2020, under the licensee's Comprehensive Home Care license and began receiving services under the licensee's Assisted Living license on August 1,	0 970		

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0 970	Continued From page 31 2021. R2 and R3's record included a [Licensee] Assisted Living Contract both signed on August 1, 2021 which contained the following statements: "Indemnification: Assured Care shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Assured Care harmless from any claims or damages unless caused solely by negligence of Assured Care. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On June 27, 2024, at 1:35 a.m. licensed assisted living director (LALD)-A stated she was unaware of the statute prohibiting a waiver of liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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01290	Continued From page 32 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of six unlicensed personnel (ULP-D, ULP-E, ULP-F, and ULP-H). This had the potential to affect all residents residing in the facility. This resulted in an immediate order on June 25, 2024. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on May 30, 2024. On June 25, 2024, at 6:15 a.m. ULP-D was observed working independently in the facility. ULP-D stated she trained a week ago and this was her first shift working unsupervised. During the shift, she completed resident checks and performed incontinent cares as needed.	01290		

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01290	Continued From page 33 ULP-D's employee record lacked evidence of a background study clearance letter. ULP-D was listed in Department of Human Services (DHS) NETStudy 2.0 as initiated on June 25, 2024, and is "in process". It also indicated that direct supervision was required. ULP-E ULP-E was hired on January 25, 2024. The licensee's Staffing Schedule identified ULP-E worked June 18, 2024, independently. ULP-E was not listed in DHS NETStudy 2.0 with background study clearance for the licensee. ULP-F ULP-F was hired on May 28, 2019. The licensee's Staffing Schedule identified ULP-F worked June 17, 2024, and June 18, 2024, independently. ULP-F was not listed on DHS NETStudy 2.0 with background study clearance for the licensee. ULP-H ULP-H was hired on September 18, 2023. The licensee's Staffing Schedule identified ULP-H worked June 22, 23, 24, 2024, independently, and is scheduled to work June 28, 2024, independently. ULP-H was not listed on DHS NETStudy 2.0 with background study clearance for the licensee.	01290		

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01290	Continued From page 34 On June 25, 2024, at 3:15 p.m. licensed assisted living director (LALD)-A stated she noted their were missing staff on NETStudy 2.0 and is working on correcting it. She was unsure why the staff were not listed. The licensee's Recruitment and Hiring policy dated April 7, 2024, identified "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. The director or designee is responsible for initiating the criminal background study for new employees ii. NETStudy 2.0 (or current version) will be used for the background check iii. The employee will be directed to locations established by DHS to obtain fingerprint scans iv. Employees will be instructed that photographic identification will be required v. Employees/study subjects may enter their own background study demographic information using the facility identification code provided vi. Results of the background study will be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was not removed prior to survey exit on June 27, 2024.	01290		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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	32366	A. BUILDING: _____ B. WING _____	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	9630 UPTON ROAD BLOOMINGTON, MN 55431

(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
01880	Continued From page 35 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents residing in the memory care unit. 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 June June 27, 2024, at 8:05 a.m. unlicensed personnel (ULP)-G set R3's medications on a desk, ULP-G left the area and went into the dining room and assisted R2 to ambulate from the dining room, passed the desk with the medications, to the living room area. ULP-G then went into the kitchen, washed his hands and put on clean gloves. The medications were not visible to ULP-G when in the dining room, living room, or the kitchen. At 8:10 a.m., ULP-G set up R3's medications, administered the medications and locked them in the cabinet. ULP-G then removed R2's medications from the locked cabinet, left the area and went into the kitchen to obtain applesauce from the refrigerator, and returned to	01880		

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01880	Continued From page 36 the living room to administer the medications. The unsecured mediations were not within ULP-G's sight when he was in the kitchen or living room, and R3 walked past the unsecured medications when ambulating from the dining room to the living room. ULP-G then locked the medications back in the cupboard. On June 27, 2024, at 1:35 p.m. licensed assisted living director (LALD)-A stated medications should not be left unattended when out of the locked cupboard. The licensee's Storage/Control of Medications policy dated April 7, 2024, identified "When A[licensee] is providing storage of medications outside of the resident ' s private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer ' s directions. Only authorized personnel have access to the stored medications." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 37 by: Based on observation, interview, and record review, the licensee failed to ensure all medications had a pharmacy label. 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 June 26, 2024, at 8:03 a.m. the surveyor observed ULP-C setting up and administering medications to R2. ULP-C removed an unlabeled bottle of ultra lubricant eye drops and administered them to R2. On June 25, 2024, licensed assisted living director (LALD)-B stated there should have been a labeled box for the eye drops and the bottle should have been stored in the labeled box. The licensee's Storage/Control of Medications policy dated April 7, 2024, indicated "Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity	01890		

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01890	Continued From page 38 c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded order from an authorized prescriber was obtained for one of two residents (R3) who received treatments. 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	01970		

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01970	Continued From page 39 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 June 26, 2024, at 8:26 a.m. unlicensed personnel (ULP)-J stated often R3 will put on her compression stockings independently. ULP-J will ask R3 if she has them on or will remind her. If R3 needed assistance with them, then ULP-J will assist. R3's service plan signed May 3, 2024, identified R3 received assistance with compression stockings two times per day. On June 27, 2024, at 12:34 p.m. licensed assisted living director (LALD)-A stated she was unable to find an order for R3's compression stockings and she had sent a message to R3's doctor. The licensee's Treatment and Therapy Management policy dated April 7, 2024, indicated the registered nurse would obtain physician orders for all treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 40 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for the licensee's two residents (R3, R2) with hospital bed rails. This resulted in an immediate correction order on June 26, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 On June 25, 2024, at 7:15 a.m. unlicensed personnel (ULP)-C was observed completing safety checks on R3. R3 was observed laying on a hospital bed with a half upper side rail, in the up position, on the right side of the bed. R3's diagnoses included dementia. R3's Service Plan dated May 2, 2024, identified R3 received assistance with bathing, dressing, grooming, compression stockings, and medication administration	02310		

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02310	Continued From page 41 R3's comprehensive assessment dated May 2, 2024, indicated R3 had a hospital bed and education had been provided; however, the assessment identified "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed". In addition, the assessment failed to identify measurements of the bed rail zones of entrapment. R2 On June 25, 2024, at 7:20 a.m. ULP-C was observed completing safety checks on R2. R2 was observed laying on a hospital bed with bilateral half upper side rails, in the up position. R2's diagnoses included dementia, stroke, traumatic brain injury, and a colostomy (surgery to create an opening for the large intestine through the abdomen). R2's Service Plan signed June 11, 2024, identified R2 received assistance with transfering, ambulation, positioning, colostomy care, dressing, grooming, bathing, medication administration, and behavior management. R2's comprehensive assessment dated May 2, 2024, identified R2 had a hospital bed with bilateral half side rails for repositioning while in bed and assisting with transfers. The assessment further identified: - "Zone 1: Is the area within the rail less than 4 3/4 inches (include measurements in note field): "yes" - Zone 2: Is the area under the rail, between rail supports or next to a single rail support less than 4 3/4 inches (note measurements in note field): "yes" - Zone 3: Is the area between the rail and	02310		

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02310	Continued From page 42 mattress less than 4 3/4 inches (include measurements in note field): "yes" - The bed rail meets FDA guidelines" The assessment failed to identify measurements of the bed rail zones of entrapment. On June 26, 2024, at 2:40 p.m. licensed assisted living director (LALD)-A stated she was unaware R3 had a side rail. LALD-A stated she was unable to locate in R3 or R2's records that the siderails had been measured. The registered nurse who completed the assessments had separated from the company. The licensee's Side Rail Use policy dated April 7, 2024, identified: "1. Before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: a. Level of mobility, including bed mobility b. Level of consciousness c. Level of cognition d. Presence of orthostatic hypotension e. Vision 2. The RN will consider the request of the resident, the resident's legal representative and/or the resident's designated representative request for side rails during the evaluation. 3. The RN will discuss with the resident/representative(s) alternatives to the use of side rails. 4. A physical therapy evaluation may be obtained, as appropriate. 5. If the need for side rails is indicated and the resident/resident representative(s) agree to their use, the RN will provide education related to side rails. 6. The RN will document the purpose of the side rails and the education provided. 7. The resident, resident's legal representative or	02310		

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02310	Continued From page 43 resident's designated representative will co-sign the document agreeing to the benefits and risks of the side rails. 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. 9. Side rails will be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations are not available, the RN will use appropriate nursing judgement related to the implementation of the side rails. 10. The need for side rails will be reassessed and documented as needed, but not less than every 90 days." The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain,	02310		

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02310	Continued From page 44 uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was not removed prior to survey exit on June 27, 2024.	02310		

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

Type: Full
Date: *06/24/24*
Time: 13:30:34
Report: 1050241120

Food and Beverage Establishment Inspection Report

Location:
Assured Care
9630 Upton Road
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0038967
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524443170
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

FACILITY DOES NOT HAVE A MN CFPM ON SITE. DISCUSSED WITH STAFF THE REQUIREMENTS AND PROVIDED THEM VIA EMAIL. STAFF CURRENTLY HAS SERVSAFE AND INTERNATIONAL FOOD SAFETY MANAGER CERT. COMPLY WITH RULE ABOVE.

Comply By: 08/27/24

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.

OBSERVED INSIDE OF MICROWAVE CAVITY COVERED IN LEFTOVER FOOD DEBRIS. DISCUSSED ESTABLISHING A CLEANING FREQUENCY WITH EMPLOYEES. COMPLY WITH RULE ABOVE.

Comply By: 06/25/24

Surface and Equipment Sanitizers

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: Sani Bucket
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *06/24/24*
Time: 13:30:34
Report: 1050241120
Assured Care

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ Orange Juice
Temperature: 39F Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Holding/ Hot Pockets
Temperature: -2F Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

Inspection was completed by MDH Andrew Spaulding and Patrice Davis. Stacy Haag was the lead Health Regulation Division Nurse Evaluator. Facility had one resident on site at time of inspection. Meals are prepared on site and leftovers are kept between 5-7 days.

Current operating staff has a International Food Safety Manager certificate as well as Servsafe. Instructions were submitted via email regarding MN CFPM certification.

Pest control is handled by Ecoshield and done on a monthly basis no pests were scene on site.

This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 1050241120 of 06/24/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Patricia Davis
Operator

Signed:_____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us