DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 11, 2024

Licensee
The Pines Assisted Living
400 West 67th Street
Richfield, MN 55423

RE: Project Number(s) SL21780015

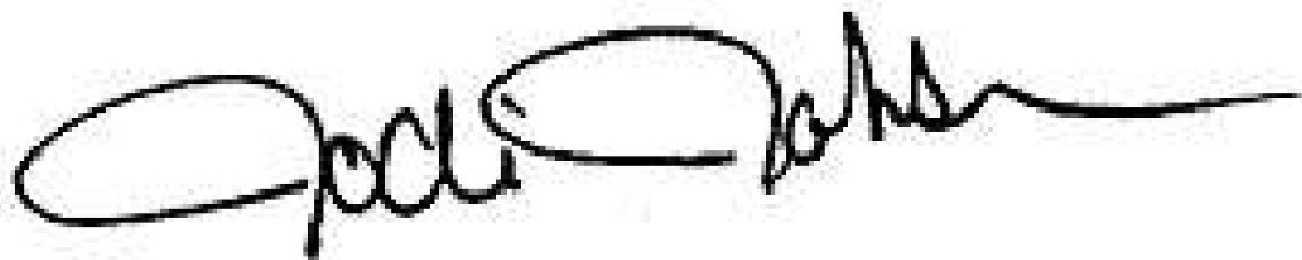
Dear Licensee:

On March 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 5, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

February 8, 2024

Licensee
The Pines Assisted Living
400 West 67th Street
Richfield, MN 55423

RE: Project Number(s) SL21780015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also

may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21780	A. BUILDING: ____ B. WING ____	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ASSISTED LIVING	400 WEST 67TH STREET RICHFIELD, MN 55423

(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: SL29362015-0 On January 2, 2024, through January 5, 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 68 residents receiving services under the Assisted Living license. An immediate correction order was identified on January 4, 2024, issued for SL21780015-0, tag identification 0830. On January 5, 2024, the immediacy of correction order 0830 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 3, 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		
0 640 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	0 640		

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0 640	Continued From page 2	0 640		

suspected vulnerable adult maltreatment by:
(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;
(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and
(3) providing reasonable accommodations with information and notices in plain language.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On January 2, 2024, at 11:30 a.m. during a facility tour with director of health services (DHS)-A, the surveyor observed a landline telephone on the first-floor end corridor in the care suites which lacked the required posting for the 911 emergency number near the landline telephone.

On January 5, 2024, at 8:25 a.m., licensed

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0 640	Continued From page 3 assisted living director (LALD)-D stated the facility's main line phone calls were diverted to the care suite's landline after 7:00 p.m. LALD-D stated the phone was available for both staff and residents to use. LALD-D stated they were unaware of the requirement. On January 5, 2024, at 8:28 a.m., the surveyor inquired if there were any other landline telephones located in the facility for resident use. LALD-D escorted the surveyor to a room located on the 1st floor, located near the main entrance to the facility, and observed a landline telephone which also lacked the required posting for the 911 emergency number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 780		

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0 780	Continued From page 4	0 780		

Continued From page 4

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 that are interconnected so actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On January 3, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D.
During the facility tour, survey staff observed the following:

In two-bedroom units 124, 208, and 224, it was observed the smoke alarm in the living room was

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0 780	Continued From page 5 interconnected to only one bedroom. Not all sleeping rooms that were equipped with smoke alarms were interconnected with the smoke alarm in the living room, so the actuation of one alarm would cause all alarms to operate. On January 3, 2024, at 10:00 a.m., LALD-D confirmed the actuation of one alarm in the two-bedroom resident unit did not cause all alarms to actuate in the dwelling unit and stated these deficient conditions were consistent in every two-bedroom resident unit in the building. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 6	0 800		

safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On January 3, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the facility tour, survey staff observed the following:

In the trash room in the basement, it was observed two fire-rated doors from the parking garage area were propped open with kick-down door stops. The kick-down doorstop will prevent the door from closing in the event of a fire.

The trash chute door in the trash room on all three floors did not self-latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system.

In the care suite dining room on the first floor, it was observed the fire-rated smoke door did not close when released from the hold-open magnet. The doors were detaching from hinges and overlapping at the top. The door is required to close and positively latch when released from the hold-open magnet to maintain fire integrity.

In the care suite area on the first floor, it was observed four resident units were located within the suite area, and the fire-rated resident unit doors were propped open with the wood wedge. Those fire-rated doors are required to self-latch to maintain the fire barrier from the corridor, and the

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0 800	Continued From page 7 door wedge will prevent the door from closing in the event of a fire. In the dining room on the first floor, it was observed the emergency egress to the exterior was sticking to the hollow metal frame, making it difficult to open, and did not latch when opened. In resident units 208, 209, and 224 on the second floor, it was observed the fire-rated unit door did not close and self-latch when tested. The door is required to automatically close and latch to maintain the fire barrier of the room. In the community lounge room on the second floor, it was observed the fire-rated smoke door did not close when released from the hold-open magnet. The fire-rated door is required to close and positively latch when released from the hold-open magnet to maintain fire integrity. During the facility tour on January 3, 2024, at 10:00 a.m., LALD-D visually verified these deficient findings at the time of discovery. 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	0 810		

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0 810	Continued From page 8	0 810		

residents; and
(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.
(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.
(d) Fire safety and evacuation plans shall be readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and

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0 810	Continued From page 9	0 810		

was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On January 3, 2024, at 12:00 p.m., licensed assisted living director (LALD)-D provided documentation on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.

FIRE SAFETY AND EVACUATION PLAN
The fire safety and evacuation plan did not include the facility-specific procedures for resident movement, evacuation or relocation during a fire or similar emergency. The facility Emergency Preparedness plan did include some provisions for the evacuation of residents but did not specify how to move or where to relocate residents during a fire, including the identification of unique or unusual resident needs for evacuation. The provided document indicated the licensee may take everyone to a large nearby church or school in case of an emergency evacuation.

During the interview on January 3, 2024, at 12:00 p.m., LALD-D stated the corporate office provided the relocation policy, the facility-specific resident relocation plan had not been implemented, and the licensee did not have any pre-arranged agreement with any organization for the resident's relocation.

DRILLS
Record review of the available documentation indicated the licensee did not conduct fire drills

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0 810	Continued From page 10 for employees twice per year per shift. Review of the provided documented drills indicated the licensee had conducted fire drills on 12/15/23 at 3:15 p.m., 10/19/23 at 3:00 p.m., 8/17/23 at 3: 00 p.m., 6/6/23 at 1:00 a.m., 4/13/23 at 3:00 p.m., and 2/16/23 at 2:00 p.m. Provided documentation indicated the licensee failed to provide two drills for the night shift. During the interview on January 3, 2024, at 12:00 p.m., LALD-D verified the licensee failed to provide two drills for the night shift, and no further drills were conducted besides those provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to using an activated electronic delivery device (vaping (inhaling) nicotine) for one of one staff members (Director of Health Services (DHS)-A). 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,	0 830	On January 5, 2024, the immediacy of correction order 0830 was removed, however non-compliance remained, and the scope and level remained unchanged.	

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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 of the residents)

This practice resulted in an immediate correction order on January 4, 2024, at approximately 3:45 p.m.

The findings include:

DHS-A was hired on April 3, 2023, to provide staff oversight, staff training, and for developing clinical procedures and policies.

On January 4, 2024, the surveyor observed the licensee's nursing office was located on the second floor of the facility, which required use of either one flight of stairs or the elevator to reach. The designated smoking area was approximately 100 feet (ft) from the nearest entrance to the facility.

On January 4, 2024, at 11:47 a.m., the surveyor observed DHS-A in a hallway space which led to the nursing office from the main space of the second floor of the facility. The surveyor observed a white round plume of smoke exhaled from DHS-A's mouth. DHS-A then turned and went into the nursing office. The surveyor then observed a yellow and pink rectangle disposable vaping device on the counter in the nursing office.

On January 4, 2024, at 12:24 p.m., licensed practical nurse (LPN)-H stated smoking and vaping were not allowed in the facility. LPN-H stated DHS-A does vape.

0 830 — 0 830

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On January 4, 2024, at 12:29 p.m., DHS-A stated they were outside vaping while taking a break just prior to when the surveyor observed them returning from their break at 11:47 a.m. DHS-A stated they did use a vape pen and was returning it to the nursing office after their break. DHS-A stated it was possible some residual vape remained in their lungs and was still being exhaled with breathing. DHS-A stated they are not allowed to vape in the facility. DHS-A showed the surveyor their vape pen which was a Lost Mary MO5000 Black Gold with blackberry, cherry, and lemon flavor.

On January 4, 2024, at 12:34 p.m., licensed assisted living director (LALD)-D stated smoking and vaping were not allowed in the facility.

On January 4, 2024, at 1:09 p.m., DHS-A stated they were very sorry, and they were under a lot of stress due to the survey. DHS-A stated they did not remember vaping in the facility but due to stress had been forgetful, "if I did it, I don't remember doing it."

The Minnesota Clean Indoor Air Act (MCIAA) indicated, "The Freedom to Breathe (FTB) provisions amended the Minnesota Clean Indoor Air Act (MCIAA) further protect employees and the public from the health hazards of secondhand smoke. These provisions went into effect on October 1, 2007. In 2019, the MCIAA was amended again to expand the definition of smoking to include vaping, the use of electronic delivery devices (also known as e-cigarettes or vapes). The amendment is effective on August 1, 2019. On August 1, 2023, adult-use cannabis was legalized in Minnesota. Vaping and smoking cannabis products is included in the definition of smoking under the MCIAA. Minnesota's cannabis

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law and local ordinances have additional requirements regarding the use of these products in the indoor environment. For more information, please contact the Office of Cannabis Management."

The MCIAA defines smoking as inhaling, exhaling, burning or carrying any lighted or heated cigar, cigarette, pipe or any other lighted or heated product containing, made or derived from nicotine, tobacco, marijuana, or other plant intended for inhalation. As of August 1, 2019, this definition includes carrying or using an activated electronic delivery device.

Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

On January 2024, at 1:25 p.m., LALD-D emailed the surveyors documentation from their Employee Handbook which indicated:
"Smoking/Tobacco use
Cassia locations provide a healthy, comfortable, and clean work environment for its employees, residents, and visitors. Thus, smoking or tobacco use is strictly prohibited within business-owned vehicles, in buildings, or outside the grounds and property.
If you choose to smoke or use tobacco, you may do so inside your vehicle or off company grounds

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during a regularly scheduled meal period. Please dispose of tobacco butts or tobacco remnants in a proper manner, and not on Cassia property. You share the responsibility for enforcing this policy. Any problems should be reported to an appropriate supervisor or the Director of Housing. If you do not comply with this policy, you are subject to the same disciplinary actions as applicable to other violations of business policies."

Employee Handbook & Cassia Site Handbook Supplement Acknowledgement of Receipt & Understanding signed on March 28, 2023, by DHS-A, indicated DHS-A received the Employee Handbook.

The licensee's No Smoking Policy form provided to residents at upon admission, undated, indicated:
"2. Definition of Smoking. The term "smoking" means inhaling, exhaling, breathing, or carrying any lighted cigar, cigarette, or other tobacco product or similar lighted product in any manner or in any form. This also applies to E Cigarettes.
3. Smoke-Free Complex. The premises to be occupied by Resident and members of Resident's household have been designated as a smoke-free living environment. Resident shall not smoke anywhere in Resident's Apartment or in the Community, including in any of the common areas, parking lot, garage or outdoor spaces. Resident shall also not permit Resident's guests or visitors to smoke in any of these locations."

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

Immediacy was removed as confirmed by the

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0 830	Continued From page 15 surveyor's on-site observation and review by evaluation supervisor on January 5, 2024; however, noncompliance remains at a scope and severity of I.	0 830		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees	01530		

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(registered nurse (RN)-B) received at least eight hours of initial dementia care training within 120 working hours of their employment start date.

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:

RN-B was hired on August 23, 2023, to provide direct services to residents.

RN-B's employee record included a Relias (online training platform) Official transcript which indicated RN-B had 7.75 hours of dementia training completed on August 30, 2023, which was 0.25 hours short of the required eight hours of dementia training.

On January 2, 2024, at 2:15 p.m., RN-E confirmed the initial dementia training for RN-B lacked 0.25 hours of training and they did not know why it was not complete.

The licensee's Orientation and Annual Training -AL-MN policy dated March 14, 2019, indicated all staff performing direct care must complete eight hours of initial dementia care training within 160 hours of employment start date.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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01530	Continued From page 17 (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessments (initial, 14-day and 90-day) to include all areas required on the uniform assessment tool for four of four residents (R3, R5, R6, R7).	01620		

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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 included:

R3
R3 was admitted to the licensee on July 31, 2023.

R3's Resident Service Agreement dated August 3, 2023, indicated R3 received services for housekeeping, laundry and meals. The service plan indicated the provider would monitor and reassess all assisted living services provided to the resident within 14 days of admission to the community's assisted living program and at least every 90 days thereafter, or more frequently if indicated by the resident's condition. The RN would conduct all reassessments and either a RN or a licensed practical nurse (LPN) under the direction of a RN would conduct all resident monitoring.

R3's record included [Licensee Name] Comprehensive Assessment forms:
- pre assessment dated and signed July 27, 2023
- admission assessment dated and signed August 2, 2023
- 14-day assessment dated September 27, 2023, and signed October 5, 2023.
- 90-day assessment signed and dated November 24, 2023

R5

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R5 was admitted to the licensee on April 12, 2019.

R5's Resident Service Agreement dated December 29, 2023, indicated R5 received services for dining, activities, grooming, laundry, and medication administration.

R5's record included [Licensee Name] Comprehensive Assessment forms which indicated 90-day assessments were completed on June 14, 2023, and October 6, 2023. The October 6, 2023, assessment was completed 114 days after the previous 90-day assessment, or 24 days past due.

R6
R6 was admitted to the licensee on October 1, 2021.

R6's Resident Service Agreement dated June 23, 2023, indicated R6 received services for bathing, dining, dressing, laundry, toileting, and medication management.

R6's record included [Licensee Name] Comprehensive Assessment forms which indicated 90-day assessments were completed on July 20, 2023, and November 7, 2023. The November 7, 2023, assessment was completed 110 days after the previous 90-day assessment, or 20 days past due.

R7
R7 was admitted to the licensee on October 3, 2021.

R7's Resident Service Agreement dated December 29, 2023, indicated R7 received services for dressing, laundry, toileting, and

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01620	Continued From page 20 medication management. R7's record included [Licensee Name] Comprehensive Assessment forms which indicated 90-day assessments were completed on: May 25, 2023 September 14, 2023; and December 28, 2023 There were 112 days between the May 25, 2023, and September 14, 2023 (22 days past due). There were 105 days between the September 14, 2023, and December 29, 2023 (15 days past due). On January 2, 2023, at 10:30 a.m. director of health services (DHS)-A stated a RN completed a comprehensive assessment on the day of admission to set-up services, within two weeks of admission, every 90 days thereafter, and with changes in the resident's condition. On January 4, 2023, at 11:10 a.m. RN-E stated R3's 14-day assessment was to be completed on time and indicated the reason was the "care history date" was not put in the electronic record. RN-E stated this caused the 14-day assessment not to be triggered for completion. RN-E stated the licensee found this inconsistency in several other resident records. On January 5, 2024, during the exit conference, DHS-A stated resident assessments were not completed timely. DHS-A stated ongoing assessments were required to be completed every 90-days. DHS-A stated they had to terminate their previous RN who oversaw completing 90-day assessments, "he was not doing his job." DHS-A stated RN-B took charge of	01620		

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01620	Continued From page 21 completing assessments after their previous nurse was let go. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of five residents (R6). 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: R6 was admitted to the licensee on October 1, 2021.	01820		

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R6's Resident Service Agreement dated June 23, 2023, indicated R6 received services for medication management.

R6's record included a Physician Order Sheet signed on August 30, 2022, which included:
-acetaminophen 325 milligrams (mg) tablets, take two tablets by mouth (PO) every four hours as needed (PRN) for mild pain;
-albuterol aerosol HFA 2 grams (G), inhale two puffs by mouth every four hours PRN for shortness of breath;
-atropine 1% solution, take 2 drops PO/sublingually every four hours PRN for secretions;
-Baclofen 5 mg tablet, take one tablet PO two times daily PRN for muscle relaxant;
-guaifenesin 400 mg tablet, take one tablet PO two times daily PRN for cough;
-lorazepam 0.5 mg tablet, take one tablet PO every four hours PRN for anxiety;
-morphine 5 mg solutab, take one solutab PO three times daily for shortness of breath (SOB) or pain;
-morphine 5 mg solutab, take one solutab PO every four hours PRN for SOB or pain;
-oxygen (O2), place resident on 5 liters (L) of O2 by nasal cannula PRN for low O2 saturation or SOB;
-Periguard ointment, 1 G apply topically to peri-area/skin folds every brief change and PRN for skin breakdown;
-quetiapine 25 mg tablet, take one tablet PO three times daily for agitation;
-Refresh Tear Drops 0.5%, instill two drops into both eyes every hour PRN for dry eyes; and
-Senna-S 8.6 - 50 mg tablet, take one tablet by PO two times daily PRN for constipation.

R6's record included Bluestone Physician

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Services medication orders for the following:
-loperamide 2 mg tablet at bedtime in addition to the current PRN order, dated October 9, 2023;
-Mucinex 600 mg tablet PO two times per day for 10 days PRN for cough/secretions, dated December 21, 2023; and
-tussin cough suppressant expectorant liquid 10-100/5 milliliters (ml) every four hours PRN for cough, dated December 20, 2023.

R6's Physician Order Sheet signed during survey on January 3, 2024. The orders were obtained in response to the surveyor's request for R6's orders. The orders indicated R6 took the following medications:
-acetaminophen 325 mg tablets, take two tablets by mouth PO every four hours PRN for mild pain;
-albuterol aerosol HFA 2 G, inhale two puffs by mouth every four hours PRN for shortness of breath;
-Baclofen 5 mg tablet, take one tablet PO two times daily PRN for muscle relaxant;
-loperamide 2 mg capsule, take one capsule PO every night at bedtime for diarrhea;
-loperamide 2 mg tablet at bedtime in addition to the current PRN order, dated October 9, 2023;
-Mucinex 600 mg tablet PO two times per day for 10 days PRN for cough/secretions, dated December 21, 2023; and
-omeprazole 20 mg capsule, take one capsule PO daily at 8:00 a.m.;
-Periguard ointment, 1 G apply topically to peri-area/skin folds every brief change and PRN for skin breakdown;
-quetiapine 25 mg tablet, take one tablet PO two times daily for agitation;
-Refresh Tear Drops 0.5%, instill two drops into both eyes every hour PRN for dry eyes;
-Senna-S 8.6 - 50 mg tablet, take one tablet by PO two times daily PRN for constipation; and

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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
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-tussin cough suppressant expectorant liquid 10-100/5 ml every four hours PRN for cough, dated December 20, 2023.

R6's Medication Sheet medication administration record (MAR) for December 2023, and January 2024, indicated R6 took the following medications:
-acetaminophen 325 mg tablets, take two tablets PO every four hours PRN for mild pain;
-albuterol aerosol HFA 2 G, inhale two puffs by mouth every four hours PRN for shortness of breath;
-Baclofen 5 mg tablet, take one tablet PO two times daily PRN for muscle relaxant;
-loperamide 2 mg capsule, take one capsule PO every night at bedtime for diarrhea;
-loperamide 2 mg tablet at bedtime in addition to the current PRN order, dated October 9, 2023;
-Mucinex 600 mg tablet PO two times per day for 10 days PRN for cough/secretions, dated December 21, 2023; and
-omeprazole 20 mg capsule, take one capsule PO daily at 8:00 a.m.;
-Periguard ointment, 1 G apply topically to peri-area/skin folds every brief change and PRN for skin breakdown;
-quetiapine 25 mg tablet, take one tablet PO two times daily for agitation;
-Refresh Tear Drops 0.5%, instill two drops into both eyes every hour PRN for dry eyes;
-Senna-S 8.6 - 50 mg tablet, take one tablet by PO two times daily PRN for constipation; and
-tussin cough suppressant expectorant liquid 10-100/5 ml every four hours PRN for cough, dated December 20, 2023.

R6's record lacked orders for the following:
-orders for the discontinuation of atropine, lorazepam, morphine and oxygen;

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-orders to start omeprazole; and
-orders to change quetiapine frequency from three times a day to two times a day.

On January 4, 2024, at 11:51 a.m., regional registered nurse (RN)-E stated R6's orders were out of date and had the provider renew the orders yesterday, January 3, 2024, during survey. RN-E stated they had no further orders to provide.

On January 4, 2024, at 11:55 a.m., RN-E provided additional orders from Bluestone Physician Services and stated they did not have further orders to provide. The orders did not address R6's discontinue atropine, lorazepam, morphine or oxygen. They did not have orders for R6 to start omeprazole or change the frequency of their quetiapine administration.

On January 5, 2024, at 10:01 a.m., licensed practical nurse (LPN)-H stated they were hired in March 2023, and came in on a consulting contract to help audit resident orders and manage medications. LPN-H stated current orders should be obtained for any medication changes and kept in the resident's record.

On January 5, 2024, at 11:19 a.m., director of health services (DHS)-A stated R6's medication orders were out of date prior to the renewed orders from January 3, 2024. DHS-A stated they did not have further orders to provide for R6. DHS-A stated a previous nurse was not doing their job and had to be let go in summer 2023, and records were behind. DHS-A stated their policy was to have an order for all discontinued medications, new medications, or changes to orders already in place.

The licensee's Medication or Physician

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01820	Continued From page 26 Orders-Implementation of-AL policy reviewed in August 2021, indicated, "1. The licensed nurse is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, to be managed by our staff are kept in the client's record and that changes in orders are addressed in the client's medical record and are communicated on a timely basis to all appropriate staff." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of five residents (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01830		

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01830	Continued From page 27 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 R6 was admitted to the licensee on October 1, 2021. R6's Resident Service Agreement dated June 23, 2023, indicated R6 received services for medication management. R6's record included a Physician Order Sheet signed on August 30, 2022, which included: -acetaminophen 325 milligrams (mg) tablets, take two tablets by mouth (PO) every four hours as needed (PRN) for mild pain; -albuterol aerosol HFA 2 grams (G), inhale two puffs by mouth every four hours PRN for shortness of breath; -atropine 1% solution, take 2 drops PO/sublingually every four hours PRN for secretions; -Baclofen 5 mg tablet, take one tablet PO two times daily PRN for muscle relaxant; -guaifenesin 400 mg tablet, take one tablet PO two times daily PRN for cough; -lorazepam 0.5 mg tablet, take one tablet PO every four hours PRN for anxiety; -morphine 5 mg solutab, take one solutab PO three times daily for shortness of breath (SOB) or pain; -morphine 5 mg solutab, take one solutab PO every four hours PRN for SOB or pain; -oxygen (O2), place resident on 5 liters (L) of O2 by nasal cannula PRN for low O2 saturation or SOB; -Periguard ointment, 1 G apply topically to peri-area/skin folds every brief change and PRN	01830		

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for skin breakdown;
-quetiapine 25 mg tablet, take one tablet PO three times daily for agitation;
-Refresh Tear Drops 0.5%, instill two drops into both eyes every hour PRN for dry eyes; and
-Senna-S 8.6 - 50 mg tablet, take one tablet by PO two times daily PRN for constipation.

R6's record included Bluestone Physician Services medication orders for the following:
-loperamide 2 mg tablet at bedtime in addition to the current PRN order, dated October 9, 2023;
-Mucinex 600 mg tablet PO two times per day for 10 days PRN for cough/secretions, dated December 21, 2023; and
-tussin cough suppressant expectorant liquid 10-100/5 milliliters (ml) every four hours PRN for cough, dated December 20, 2023.

On January 4, 2024, R6's Physician Order Sheet signed January 3, 2024, were provided by regional registered nurse (RN)-E. R6's annual orders were due to be signed by August 30, 2023, but were signed during survey on January 3, 2024. The following medications were past due for annual renewal:
-acetaminophen 325 mg tablets, take two tablets PO every four hours PRN for mild pain;
-albuterol aerosol HFA 2 G, inhale two puffs by mouth every four hours PRN for shortness of breath;
-Baclofen 5 mg tablet, take one tablet PO two times daily PRN for muscle relaxant;
-loperamide 2 mg capsule, take one capsule PO every night at bedtime for diarrhea;
-Periguard ointment, 1 G apply topically to peri-area/skin folds every brief change and PRN for skin breakdown;
-quetiapine 25 mg tablet, take one tablet PO two times daily for agitation;

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-Refresh Tear Drops 0.5%, instill two drops into both eyes every hour PRN for dry eyes; and
-Senna-S 8.6-50 mg tablet, take one tablet by PO two times daily PRN for constipation.

On January 4, 2024, at 11:51 a.m., RN-E stated R6's orders were out of date and had the provider renew the orders yesterday, January 3, 2024. RN-E stated the annual order renewal for R6 must have been overlooked. RN-E stated they had no further orders to provide.

On January 5, 2024, at 10:01 a.m., licensed practical nurse (LPN)-H stated they were hired in March 2023, and came in on a consulting contract to help audit resident orders and manage medications. LPN-H stated orders needed to be renewed annually. LPN-H stated current orders should be obtained for any medication changes and kept in the resident's record.

On January 5, 2024, at 11:19 a.m., director of health services (DHS)-A stated R6's medication orders were out of date. DHS-A stated medication orders should have been updated annually but were overlooked, and had them signed yesterday, January 3, 2024. DHS-A stated a previous nurse was not doing their job and had to be let go in summer 2023, and records were behind.

The licensee's Medication or Physician Orders-Implementation of-AL policy last revised August 2021, indicated, "7. The RN or LPN will assure that the prescriber renews a medication prescription at least every 12 months, or more frequently if determined necessary based on the nursing assessment."

No further information was provided.

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01830	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications were included in the assessment for medication management or documented in the resident record for one of two residents (R9). 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: R9's service plan dated May 1, 2023, indicated R9 received medication management services. R9's Physician's Order Sheet dated January 27, 2023, included the following new orders handwritten by the physician:	01870		

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01870	Continued From page 31 -PreserVision two a day; and -Calcium/vitamin D one tab twice a day. A note from the physician read: "both OTC, patient purchase and self-administer." R9's Self-Administration of Medication (SAM) assessment dated December 19, 2023, indicated R9 was to safely self-administer nebulizer/albuterol and PreserVision chewable. SAM did not include Calcium/vitamin D. R9's medication administration record (MAR) for January 2024, did not include Calcium/vitamin D. On January 4, 2024, at 9:00 a.m., the surveyor observed two bottles of medication sitting on the kitchen countertop by the sink. One was a white bottle with green, red, and blue label containing PreserVision. The second one was purple bottle containing Caltrate bone chewable (Calcium/vitamin D, 600+D3). On January 5, 2024, at 10:57 a.m., director of health service (DHS)-A, stated R9 received a sample from the eye doctor and did not let the nursing team know. DHS was not aware there was a physician order for the Caltrate bone chewable (Calcium/vitamin D, 600+D3) to be taken independently. The licensee's Medication Administration AL policy read: "4. Each resident has the right to self-administer medications if they desire. If resident expresses a desire to self-administer medications, the policy for self-administration of medication will be followed. 5. Residents who have an order to self-administer medications and have approval to keep these medications at the bedside will keep those medications in a locked drawer or box in their room."	01870		

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01870	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for two of two residents (R5, R10). 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: R5 R5's Resident Service Agreement dated December 29, 2023, indicated R5 received medication management services. R5's Physician Order Sheet signed and dated	01880		

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June 13, 2023, indicated R5 took:
-acetaminophen 500 milligram tablets, take two tablets (1000 mg) by mouth (PO) twice daily; and
-levetiracetam 500 mg tablets, take one tablet PO twice a day.

R5's Medication Sheet (medication administration record (MAR)) for December 2023, and January 2024, indicated R5 took:
-acetaminophen 500 mg tablets, take two tablets (1000 mg) PO twice daily; and
-levetiracetam 500 mg tablets, take one tablet PO twice a day.

R10
R10's Resident Service Agreement dated December 28, 2023, indicated R10 received medication management services.

R10's Bluestone Physician Order signed and dated December 27, 2023, included:
-melatonin 3 mg, one tablet PO at bedtime for sleep.

R10's MAR for December 2023, and January 2024, included:
-melatonin 3 mg, one tablet PO at bedtime for sleep.

On January 2, 2024, at 11:23 a.m., the surveyor observed a hallway space outside of the nursing office door with director of health services (DHS)-A. The surveyor observed a yellow basket approximately 12x6x4 inches in size which included one bubble pack of melatonin 3 mg tablets, belonging to R10, and a small container of Assure Prism Blood Glucose Test strips (50 count) with, "JH 1/1/24," written in black marker. The surveyor inquired why the medication was left out and not locked up. DHS-A stated the door

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to the hallway locked. The surveyor examined the hallway door which did not have a locking mechanism on it. DHS-A stated, "oh, I guess it doesn't lock."

On January 3, 2024, at 10:01 a.m., the surveyor observed unlicensed personnel (ULP)-F perform medication administration for R5. ULP-F crushed R5's acetaminophen and levetiracetam medications and mixed them with apple sauce in a small two-ounce medication administration cup. ULP-F brought the crushed medications into R5's room and set the cup on R5's table. ULP-F then left the room to get a glass of water leaving the medications unattended with the resident and surveyors. ULP-F returned after approximately 45 seconds with a glass of water and administered the medication. ULP-F stated, "I suppose I should have taken these meds with me."

On January 4, 2024, at 9:14 a.m., ULP-F stated medications should be locked and secured when unsupervised at all times.

On January 5, 2024, at 10:01 a.m., licensed practical nurse (LPN)-H stated ULP-F should not have left the medications alone with R5 without being locked up. ULP-F should have taken the pills with them when they left the room. LPN-H stated the hallway space outside of the nursing office door was where they were storing medication to be delivered to resident rooms until they realized the door didn't lock when pointed out by the surveyors. LPN-H stated they were relocating where they put those medications to a secure locked room.

On January 5, 2023, at 11:19 a.m., DHS-A stated the yellow basket in the hallway space outside of the nursing office door was where they put

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medications after they were reviewed by nursing and ready to be put in the resident's storage cabinet in the resident's room. They stated sometimes they could not find a ULP to take the medication to the resident's room and would be put in the basket until a ULP was available to do so. The surveyor inquired if nurses were allowed to bring medications to the resident's room, DHS-A stated, "yes." DHS-A stated it is a process they likely need to get rid of as it added an extra step which could lead to errors. DHS-A stated they did not realize the hallway door did not have a lock on it until the surveyor pointed it out to them. DHS-A stated all staff, residents, and visitors had access to the medications in the hallway since the door did not lock. DHS-A stated ULP-F should not have left medications unsupervised in R5's room. DHS-A stated ULP were trained to keep medications secure at all times.

The licensee's Medication Storage-AL policy revised on March 22, 2023, indicated, "8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents." It further indicated, "Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys."

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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02310	Continued From page 36	02310		
02310 SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards when they failed to complete required 90-day bed rail assessments for two of three residents (R5, R6) who utilized consumer and hospital bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5's Resident Service Agreement dated December 29, 2023, indicated R5 received services for bathing, dining, grooming, medication administration, toileting, and bed mobility. R5's record included three MN-Device Assessments dated June 14, 2023, October 6, 2023, and December 29, 2023, which included	02310		

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02310	Continued From page 37	02310		

bed rail assessments. The assessments on October 6, 2023, exceeded the 90-day assessment frequency requirement for bed rails by 24 days.

On January 3, 2024, at 1:12 p.m., the surveyor observed R5's bed which had consumer Halo bed rails on both sides of the bed. The surveyor wiggled and pulled on both bed rails which were firmly attached to the bed.

R6
R6's Resident Service Agreement dated June 23, 2023, indicated R6 received services for bathing, dining, activities, dressing, toileting, grooming and transfer assist.

R6's record included three MN-Device Assessments dated May 2, 2023, June 20, 2023, and November 7, 2023, which included bed rail assessments. The assessments on November 7, 2023, exceeded the 90-day assessment frequency requirement for bed rails by 50 days.

On January 3, 2024, at 8:10 a.m., the surveyor observed R6's hospital bed which were rectangle half-rails with vertical bars on both sides of the bed. The surveyor wiggled and pulled on both bed rails which were firmly attached to the bed.

On January 3, 2024, at 12:08 p.m., regional registered nurse (RN)-E stated the device assessments for R5 and R6 each had an assessment completed late exceeding the 90-day requirement. They stated they were aware of the 90-day bed rail assessment frequency requirement.

On January 3, 2024, at 12:32 p.m., director of health services (DHS)-A stated R5's bed rail

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21780	A. BUILDING: ______ B. WING ______	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ASSISTED LIVING	400 WEST 67TH STREET RICHFIELD, MN 55423

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02310	Continued From page 38	02310		

assessments were not completed on time and was aware of the 90-day bed rail assessment frequency requirement. DHS-A stated they had a previous RN who wasn't doing their job and had to terminate their employment. DHS-A stated they had outsourced to get temporary nursing assistance to help catch up on their assessments.

The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, 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) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame."

The licensee's Physical Device Safety - Side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21780	A. BUILDING: ______ B. WING ______	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ASSISTED LIVING	**400 WEST 67TH STREET RICHFIELD, MN 55423**

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02310	Continued From page 39 Rails policy last reviewed and revised on November 13, 2023, indicated, "Continued use of physical devices must be assessed at least every 90 days to determine if the device still is needed to enhance the resident's safety and/or bed mobility." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received appropriate care and services from one of one unlicensed personnel (ULP-C) during medication administration. 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	02320		

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02320	Continued From page 40	02320		

situation has occurred only occasionally).

The findings include:

R9's prescription dated January 27, 2023, indicated R9 took the following medication:
-Lantus solos injection (INJ) 100/milliliter (ml), inject 18 units (U) subcutaneous (SQ) every morning, Prime 2 U prior to injection. Hold if blood sugar is less than 80; notify nursing.

R9's medication administration record (MAR) for January 2024, indicated:
-Lantus solos INJ 100/ml, inject 18 U SQ every morning, Prime 2 U prior to injection. Hold if blood sugar is less than 80; notify nursing.

On January 4, 2024, at 9:00 a.m., the surveyor observed R9's morning insulin administration conducted by unlicensed personnel (ULP)-C. ULP-C used R9's glucometer (device used to measure blood glucose (BG) levels) to check R9's BG which was 147. ULP-C obtained R9's Lantus Solostar Insulin Pen from the medication cabinet, attached the disposable needle to the insulin pen, primed it with two units and dialed it to 18 U. ULP-C was about to administer the Lantus to R9's left lower quadrant (LLQ) of the abdomen without cleaning the site. The surveyor also observed ULP-C did not look at R9's MAR on Eldermark (electronic medication administration record software) and did not check the five rights. The surveyor stopped ULP-C from administering the insulin. The surveyor inquired if ULP-C had cleaned the injection site. ULP-C stated they usually did not clean the injection site before administering the insulin as the abdominal area is usually clean. ULP-C then cleaned the site and attempted to administer the insulin to LLQ without checking the MAR for the second time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21780	A. BUILDING: ______ B. WING ______	01/05/2024

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02320	Continued From page 41	02320		

when the surveyor stopped the ULP from administering the insulin. The surveyor inquired if ULP-C had checked the MAR in Eldermark. ULP-C stated "yes," they checked the MAR before they came into the room. The surveyor asked to see the MAR. ULP-C took out their phone from their pocket and signed into Eldermark, downloaded the resident record and showed the surveyor the order to check for BG and order to administer 18 U of Lantus in the morning. ULP-C then administered the insulin and documented the administration in Eldermark.

On January 4, 2024, at 10:21 a.m., ULP-C stated they were told by the previous director of health service (DHS) not to clean the injection site as the abdominal area was usually clean.

On January 4, 2024, at 10:21 a.m., DHS-A stated their expectation for insulin administration was to check the order against the MAR while the ULP are in the resident's room before administering insulin. DHS-A also stated the injection site had to be cleaned before insulin administration.

The licensee's Insulin pen-AL (IA-MN-ND) policy dated December 18, 2019, read:
"5. Check medication label with eMAR. (Confirm right resident, medication, dose, dosage form, frequency and route). (If a resident has had frequent insulin order changes, check with the current physician orders)

Dial the correct dose:
a. Make sure there is enough insulin in the pen for your full dose.
b. Set the dose selector at 0 in the dose display area. Dial your insulin dose. Check the insulin display area to make sure you have dialed the right dose.

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	21780	A. BUILDING: ______ B. WING ______	01/05/2024

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02320	Continued From page 42	02320		

6. Check the dose window before each use to be sure you have dialed the correct dose of insulin.
7. Apply gloves
8. Select injection site and cleanse with alcohol wipe. Sites are rotated.

Using pen to inject insulin:
a. Insulin is injected into the abdomen, thighs and arms.
b. Clean the injection site with a sterile alcohol swab, letting skin dry before proceeding with the injection.
c. Spread skin tightly across injection site or pinch skin with non- dominant hand. Hold the insulin pen at a 90 degree angle and insert the needle all the way into the skin.
d. Let go of the stretched or pinched skin. Inject the insulin by pushing the button on the insulin pen all the way in. Keep the button pressed and count to 10 before removing the needle from the skin."

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Full
Date: *01/03/24*
Time: 10:30:00
Report: 1043241002

Food and Beverage Establishment Inspection Report

Location:
The Pines Assisted Living
400 West 67th Street
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038218
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128613331
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.

5-200B Plumbing: cross connections

5-203.14E ***** Priority 1 *****

MN Rule 4626.1085A Mount the spray arm so it cannot hang below the spill rim of a sink or provide an approved backflow prevention device on the faucet.

HOSE AT MOP SINK OBSERVED TO BE HANGING PAST THE SPILL RIM. DISCUSSED PROPER HOSE LENGTH WITH STAFF. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: COOK LINE SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: PREP AREA SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: COOK LINE COOLER STATION
Violation Issued: No

Process/Item: TOMATO
Temperature: 40 Degrees Fahrenheit - Location: COOK LINE COOLER STATION
Violation Issued: No

Process/Item: CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: COOK LINE COOLER STATION
Violation Issued: No

Process/Item: CHILI
Temperature: 180 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: SOUP OF THE DAY
Temperature: 173 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: HAM
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

Inspection was completed with K. Robinson. M. Bruess was the lead Health Regulation Division Nurse Evaluator completing the site survey. Items on report were discussed with J. Keen (HRD) on-site.

Discussed highly susceptible population, date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food/equipment/utensil storage, and food handling procedures.

*Facility has a commercial kitchen.

If any customer complains of illness, establishment is required to notify the Minnesota department of health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Always contact sanitarian or MDH plan review prior to any modifications, remodeling, or construction.

Always contact sanitarian or MDH prior to any official change of ownership.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241002 of 01/03/24.

Certified Food Protection Manager: Roberto Mendoza-Alvarado

Certification Number: FM81520 Expires: 12/05/24

Inspection report reviewed with person in charge and emailed.

Signed: ______________________

Kari Robinson
PIC

Signed:

Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us

Report #: 1043241002

Food Establishment Inspection Report

Minnesota Department of Health

625 Robert St N
St. Paul

No. of RF/PHI Categories Out	0	Date 01/03/24
No. of Repeat RF/PHI Categories Out	0	Time In 10:30:00
Legal Authority MN Rules Chapter 4626		Time Out

The Pines Assisted Living	Address	City/State	Zip Code	Telephone
	400 West 67th Street	Richfield, MN	55423	6128613331

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038218		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

(Circled status shown in parentheses.)

#	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

#	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) — **Date:** 01/03/24

Inspector (Signature) [signature]