Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 11, 2023

Licensee
Epiphany Assisted Living, LLC
10955 Hanson Boulevard Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL30688015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

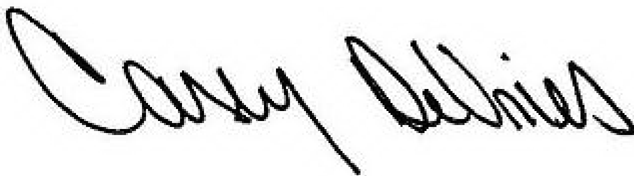
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30688	A. BUILDING: ____ B. WING ____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY ASSISTED LIVING LLC	**10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433**

(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: SL#30688015-0 On April 24, 2023, through April 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 72 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content (annual performance review) for one of two employees, (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the	0 650		

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0 650	Continued From page 2	0 650		

situation has occurred only occasionally).

Findings include:

RN-C had a hire date of April 4, 2022. RN-C's employee record lacked evidence an annual performance review was completed.

On April 24, 2023, at 2:18 p.m., surveyor requested RN-C's annual performance review. Licensed assisted living director (LALD)-B stated, " Human Resources (HR) would need to located RN-C's annual performance review, and would be back in the office tomorrow."

On April 25, 2023, at 8:30 a.m., LALD-B confirmed RN-C's employee file lacked documentation of an annual performance review. LALD-B stated, " I am not sure what performance evaluations the previous executive director completed, so I am unable to confirm that all employee annual performance reviews were up to date."

Licensee's Supervision of Unlicensed Personnel policy dated January 27, 2023, indicated the Clinical Nurse Supervisor and Home Care Director would be responsible for completing an annual performance review of each home care staff person, based on the documentation of the supervisor's observations and other relevant information.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days

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0 660	Continued From page 3	0 660		
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 baseline testing and screening for two of three employees (unlicensed personnel (ULP)-E, ULP-I). 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).	0 660		

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0 660	Continued From page 4	0 660		

The findings include:

The licensee's TB facility risk assessment worksheet dated November 16, 2022, indicated the licensee's setting was a low risk for TB.

ULP-E
ULP-E was hired on July 8, 2022.

ULP-E's TB record included a first step Mantoux (method of determining whether a person is infected with Mycobacterium tuberculosis done by injection in skin) completed on July 8, 2022, with a negative result. ULP-E's My Transcript indicated ULP-E completed TB training on July 14, 2022, and a TB history questionnaire on July 25, 2022.

ULP-E's record lacked a second step Mantoux skin test.

ULP-I
ULP-I was hired on March 3, 2023.

ULP-I's TB record included a TB history questionnaire completed on March 3, 2022, and QuantiFERON (method of determining whether a person is infected with Mycobacterium tuberculosis done by blood test) dated March 3, 2023, with no documented results.

ULP-I's record lacked testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test with an interpretation.

On April 25, 2023, at 2:30 p.m., assistant executive director (AED)-D stated the required documentation was missing in the employees' files. AED-D also stated licensee had recognized issues with in-house testing as it was difficult to

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0 660	Continued From page 5 follow up. The Minnesota Department of Health- Regulations for Tuberculosis Control in Minnesota Health Care Settings dated November 10, 2022, indicated there are two methods available to screen for TB infection: the tuberculin skin test (TST) and the Interferon Gamma Release Assay (IGRA). Also indicated, all reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record. The Centers for disease Control and Prevention- Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated guidelines for preventing Mycobacterium tuberculosis transmission in health care settings include recommendations for baseline tuberculosis (TB) screening of all U.S. health care personnel. Licensee's TB Prevention and Control policy dated January 17, 2023, indicated licensee will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), and the Minnesota Department of Health guidelines. 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	0 680		

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0 680	Continued From page 6 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 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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to 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	0 680		

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0 680	Continued From page 7 or has the potential to affect a large portion or all of the residents). The findings include: The licensee's plan dated March 21, 2023, lacked the following required content: - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents; - policies and procedures on volunteers; On April 24, 2023, at 2:00 p.m., assistant executive director (AED)-D confirmed the licensee's emergency preparedness plan lacked the above listed required content, and stated licensee was not aware of all the required content of Appendix Z. The licensee's Plans for Emergencies and Natural Disasters policy dated December 28, 2022, indicated the licensee would have a written plan of action to facilitate their client's [resident's] care and services in response to a natural disaster or another type of emergency that may affect their ability to provide services, and their plan would be updated regularly and would be coordinated with local emergency responders, and where appropriate, with the management of senior housing buildings or housing with services establishments where their clients live. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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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, 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. 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, 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 April 25, 2023, from approximately 12:30 p.m. to 2:00 p.m. with the licensed assisted living director (LALD)-B and the Director of Maintenance (DM)-K it was observed that there was a hamper of soiled linens being	0 800		

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0 800	Continued From page 9 stored in the exit stairwell of the second-floor memory care unit. Miscellaneous items were being stored in the exit stairwells throughout the building compromising exiting for staff and residents due to not maintaining the path of egress and areas of refuge. - Stair A, the second floor had a door leaf stored in the area of refuge. - Stair A, the third floor had a cart, microwave, and wood boards stored in the area of refuge. - Stair B, the third floor had three stoves, two chairs, and civil green chemicals stored in the area of refuge. The fire-rated door to the egress stairs on the second floor of Stair C did not close on its own when opened 90 degrees. It appeared that the door was catching on the carpeting and holding the door in the open position. Fire-rated doors to egress stairs should close and positively latch to maintain the fire resistance integrity of the egress stairwell. LALD-B and DM-K 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;	0 810		

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0 810	Continued From page 10 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with 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. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 11 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: A record review and interview were conducted on April 25, 2023, at approximately 2:15 p.m. with the the licensed assisted living director (LALD)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-B verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=D	144G.50 Subd. 3 Designation of representative	0 950		

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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
0 950	Continued From page 12	0 950		

(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:

"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.

You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."

(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to complete documentation for the opportunity to identify a designated representative in writing by not requiring the contract section to be filled out, for one of five residents (R4).

This practice resulted in a level two violation (a

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	30688	A. BUILDING: ___ B. WING ___	04/26/2023

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0 950	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when 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: R4 was admitted October 18, 2022, and received services including assistance with medication administration, bathroom assistance, dressing and undressing, and bathroom safety checks. R4's resident contract dated October 18, 2022, had a page to designate a representative, however was left blank and lacked acknowledgment of the resident to indicate if they declined to name a designated representative, or chose to name a representative. On April 25, 2023, at 8:30 a.m., licensed assisted living director (LALD)-B stated licensee usually has the resident or resident's power of attorney fill out that section for designated representative and did not know why they had not completed on this contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 14 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 72 residents living within the assisted living 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, 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 April 24, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-B provided the surveyor a blank contract and indicated the contract was used by licensee for all residents. Page 22 section 40 Liability included: "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property	0 970		

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0 970	Continued From page 15 damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third party providers." On April 24, 2023, at 11:15 a.m., LALD-B stated the licensee was not aware that the assisted living with dementia care contract included a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 16 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, for two of two residents (R2, R3) and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01060		

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01060	Continued From page 17	01060		

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:

R2
R2 was admitted to licensee on March 2, 2022, and started receiving assisted living services.

R2's service agreement dated March 5, 2023, indicated R2 received services to include registered nurse (RN) comprehensive assessment, medication administration, monthly weights and vital signs, bathing, pendant checks, and filling of portable oxygen tanks.

R2's progress note dated November 2, 2022, at 8:08 a.m., indicated R2 was found on the floor in her bathroom lying flat on her back with her knees bent up at 4:30 a.m., and R2 stated that she just fell and hit her head. The note indicated at 7:00 a.m., staff were able to convince R2 to go to the hospital and the licensee called R2's physician group and R2's sister to inform them of R2's decision to be sent to the hospital.

R2's progress note dated January 13, 2023, at 10:11 a.m., indicated R2 was readmitted to the licensee's facility from a transitional care facility. R2 was relocated from the facility for 71 days from November 2, 2022, through January 12, 2023.

R2's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the

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01060	Continued From page 18	01060		

emergency relocation greater than four days as required.

R3
R3 was admitted to licensee on October 24, 2022, and started receiving assisted living services.

R3's service agreement dated October 24, 2022, indicated R3 received services to include: bathroom assistance, dressing and undressing assistance, medication administration, and safety checks.

R3's progress note dated February 24, 2023, indicated R3 tested positive for COVID on February 23, 2023, and was having erratic behaviors. The licensee called R3's nurse practitioner, and the decision was made to send R3 to the emergency room. The note indicated the licensee informed R3's daughter. Non-emergency transport arrived at facility and transported R3 to hospital around 11:50 am., and R3 remained in the hospital from February 24, 2023, through February 27, 2023.

R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice.

On April 25, 2023, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated the licensee had not provided to the resident, resident's representative or to the ombudsman's office the required notices for emergency relocation as the facility was not aware of the requirement. CNS-A further stated they had not provided the required notices for any relocations because they did not know they should.

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01060	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after tasks were delegated for two	01440		

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01440	Continued From page 20	01440		

of two unlicensed personnel ((ULP)-E, ULP-I).

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-E
ULP-E started employment with the licensee July 8, 2022.

On April 25, 2023, from 7:15 a.m., through 9:30 a.m., the surveyor observed ULP-E administer medications to residents of the dementia care unit.

ULP-I
ULP-I started employment with the licensee March 3, 2023.

On April 25, 2023, at 8:24 a.m., the surveyor observed ULP-I and ULP-J assist R11 to transfer into recliner wheelchair in her room.

ULP-E's and ULP-I's employee record lacked direct supervision performing delegated tasks within 30 calendar days after the date on which the ULPs first performed delegated tasks for residents and thereafter as needed based on performance.

On April 25, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated ULP-E and ULP-I's record lacked documentation of supervision by

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01440	Continued From page 21 the RN within 30 calendar days from the date of first performing a delegated task and thereafter as needed based on performance. CNS-A also stated the 30-day supervisions would not be available in any ULPs records as the licensee did not have a system in place to keep track of the requirement. The licensee's Supervision of Unlicensed Personnel policy dated January 27, 2023, indicated "unlicensed personnel will be supervised by designated supervisors to ensure that the staff is performing their job duties competently, consistently with any professional standards that may apply and consistently with company policy and procedures." Also indicated "direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	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	01530		

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01530	Continued From page 22 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 supervisors of direct care staff received the required amount of dementia care training in the required time frame for one of one employee (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01530		

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01530	Continued From page 23 The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through August 31, 2023. RN-C's record lacked documentation of the required eight (8) hours of dementia training within 120 working hours of the employment start date. RN-C was hired April 4, 2022. RN-C's record included 4.25 hours of dementia care training in the required topics, completed between April 4, 2022, and April 5, 2022. RN-C's My Transcript training record indicated RN-C completed a total of four hours and fifteen minutes (4.25) credits in the following topics: - dementia- activities- a balanced approach- 0.75 credits - dementia- communication overview- 1.00 credits - dementia overview- overview- 1.00 credits - dementia- person-centered care- 0.75 credits - dementia- problem solving overview- 0.75 credits On April 25, 2023, 2:01 p.m., licensed assisted living director (LALD)-B stated RN-C's record lacked the required eight (8) hours within 120 working hours of the employment start date. LALD-B also stated staff were to complete the required dementia care training on EduCare (a training software system) and thought the assigned topics would cover the statute requirement of eight (8) hours within 120 working hours of the employment start date, hence none of the other employees would have met the requirement.	01530		

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01530	Continued From page 24 The licensee's Dementia Training and Disclosure Requirements policy dated February 2, 2023, indicated "Our agency provides required dementia training to all direct care staff and their supervisors and makes appropriate disclosures to clients and client representatives who request the information." The policy lacked verbiage to include the required topics and time frame within which to complete the training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be 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:	01540		

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01540	Continued From page 25 Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for one of one employee (unlicensed personnel (ULP-E)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through August 31, 2023. ULP-E started employment with the licensee July 8, 2022. On April 25, 2023, from 7:15 a.m., through 9:30 a.m., the surveyor observed ULP-E administer medications to residents of the dementia care unit. ULP-E's My Transcript training record indicated ULP-E completed a total of five (5) credits in the following topics: - dementia overview- Alzheimer's disease- 0.75 credits - dementia overview- Lewy body dementia- 0.75 credits - dementia overview- multi-infarct dementia- 0.75 credits - dementia overview- other types of dementia-	01540		

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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
01540	Continued From page 26 0.75 credits - dementia- person-centered care- 0.75 credits - dementia management and abuse prevention- 0.75 credits On April 25, 2023, 2:01 p.m., licensed assisted living director (LALD)-B stated ULP-E's record lacked the required eight (8) hours within 80 working hours of the employment start date. LALD-B also stated staff were to complete the required dementia care training on EduCare (a training software system) and thought the assigned topics would cover the statute requirement of eight (8) hours within 80 working hours of the employment start date, hence none of the other employees would have met the requirement. The licensee's Dementia Training and Disclosure Requirements policy dated February 2, 2023, indicated "Our agency provides required dementia training to all direct care staff and their supervisors and makes appropriate disclosures to clients and client representatives who request the information." The policy lacked verbiage to include the required topics and time frame within which to complete the training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan was revised to include all services being provided for two of five residents (R3, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R3
R3 diagnoses included Alzheimer's disease,

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unilateral primary osteoarthritis left knee, vitamin D deficiency, and acute pericarditis.

R3's provider orders signed and dated March 1, 2022, indicated R3 received hospice services with skilled nursing, medical social worker, chaplain, hospice aide, music therapy, massage therapy, volunteer services and wound care. Wound care ordered three times a week to include: remove dressing, place ice and ace wrap to area, pat dry, wound measurements weekly.

R3's Service Plan signed October 24, 2022, indicated R3 received services to include medication management, nursing assessments, bathroom assistance, bathroom safety checks, and dressing and undressing.

R3's Hospice plan of care indicated R3 was receiving hospice services with skilled nursing, medical social worker, chaplain, hospice aide, music therapy, massage therapy, volunteer services and wound care. Wound care ordered three times a week to include: remove dressing, place ice and ace wrap to area, pat dry, wound measurements weekly.

R3's service plan lacked identification of hospice services and wound care.

R4
R4's diagnoses were dementia without behavioral disturbances, chronic atrial fibrillation, type 2 diabetes mellitus with unspecified complication, and chronic kidney disease stage 3a, hypertension, gout, and polymyalgia rheumatica.

R4's provider orders signed and dated March 22, 2022, indicated R4 received blood glucose sugar checks, one time daily.

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01640	Continued From page 29 R4's Service Plan dated October 24, 2023, indicated R4 received the following services: nursing services and assessments, memory care services, AM care, PM cares, bathing assistance, housekeeping, and laundry services. R4's Medication sheet dated April 2023, indicated R4 received medication administration and blood sugar checks daily at 7:30 p.m. R4's service plan lacked identification of blood glucose monitoring and medication administration. On April 25, 2023, at 1:15 p.m., registered nurse (CNS)-A stated R4 received daily medication administration and daily blood sugar checks. CNS-A also stated that R3 was on hospice services since the beginning of March and was getting wound care at that time. CNS-A further stated she was not totally aware of everything that was required to be on the service plan but would review the statute and update the current service plans to include all requirements. Licensee's Content of Service Plan policy dated February 22, 2023, indicated the service plan, including each revision is entered into the client's [resident's] record. The service plan is revised and signed by the RN and or other licensed health professional and the client or the clients representative any time home care services change based on changes in the client's needs and preferences and any time our agency's fee schedule changes. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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01640	Continued From page 30 (21) days	01640		
01880 SS=D	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 secure medications to be accessed by authorized individuals only for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's diagnoses included Alzheimer's disease, unilateral primary osteoarthritis left knee, vitamin D deficiency, and acute pericarditis. R3's Service Plan signed October 24, 2022, indicated R3 received services to include medication management, nursing assessments, bathroom assistance, bathroom safety checks, and dressing and undressing. On April 24, 2023, at approximately 7:40 a.m., the	01880		

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01880	Continued From page 31 surveyor observed R3's bathroom during morning cares and noted unsecured medications stored on the bathroom counter. Medications kept unsecured at the bedside included, Z Guard Paste, and A & D Ointment. On April 24, 2023, at 8:07 a.m., clinical nurse supervisor (CNS)-A stated all medications should remain stored in locked cabinet in medication cart, never to be left at the bedside or unattended in memory care. The licensee's Storage of Medications policy revised January 27, 2023, indicated in the client's [resident's] individualized medication plan, the RN may identify the need for secure storage of the medications within the clients private living space or central storage are in a senior housing setting because of the client's cognitive status, concerns about medication diversion or other concerns. When secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 32	01890		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label, in addition, licensee failed to ensure expired medications were disposed properly. This had the potential to affect all residents of the first-floor dementia 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 April 25, 2023, at approximately 7:57 a.m., the surveyor conducted a review of the locked medication cart on the first floor in the dementia unit with unlicensed personnel (ULP)-E, and made the following observations:
- Ketoconazole cream 2%- unlabeled,
- Lubricating jelly II- unlabeled and expired in May 2022.

On April 25, 2023, at 8:10 a.m., ULP-E stated the medication cart had unlabeled and expired medications and could not identify who they belonged to. ULP-E also stated the cart was audited weekly to remove expired medication and all medications are supposed to be labeled.

On April 25, 2023, at 11:23 a.m., clinical nurse supervisor (CNS)-A stated the medication cart is

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01890	Continued From page 33 audited by a nurse weekly, but did not know how the unlabeled medication and the expired medication were missed in the last week audit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability 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, but was not likely to	02040		

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02040	Continued From page 34 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: A record review and interview were conducted on April 25, 2023, at approximately 2:30 p.m. with the licensed assisted living director (LALD)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-B verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and	02110		

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design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;
(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
(5) staff training specific to dementia care;
(6) description of life enrichment programs and how activities are implemented;
(7) description of family support programs and efforts to keep the family engaged;
(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;
(9) transportation coordination and assistance to and from outside medical appointments; and
(10) safekeeping of residents' possessions.
(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop and implement the required policies and procedures for assisted living with dementia care (ALFDC), and ensure the policies were provided to residents or the resident's legal and /or designated representative at the time of move-in for five of five residents (R1, R2, R3, R4, R5).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a

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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 had a current assisted living facility with dementia care (ALFDC) license effective August 1, 2022.

R1 was admitted to the licensee on December 01, 2022.

R2 was admitted to the licensee on March 02, 2022.

R3 was admitted to the licensee on October 24, 2022.

R4 was admitted to the licensee on October 18, 2022.

R5 was admitted to the licensee on February 22, 2022.

The licensee's lacked required written policies for assisted living facility with dementia care that addressed:
(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;
(2) evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that are person-centered and evidence-informed;
(3) wandering and egress prevention that

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02110	Continued From page 37 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. R1, R2, R3, R4, and R5's resident record lacked evidence the licensee provided the resident or resident representative the 10 required dementia care policies and procedures addressed in 144G.82 Subd. 3., at the time of move-in to the facility. On April 25, 2023, at 2:52 p.m., licensed assisted living director (LALD)-B stated the dementia care training program was provided to residents in the admission packet. LALD-B further stated residents should have signed an "Acknowledgement of Recipient Rights" form indicating they received the dementia care policies. LALD-B was unable to provide the surveyor with the policies, and none of the documents provided contained the required 10 dementia care policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02110		

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02110	Continued From page 38 (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required competency test. 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: During the entrance conference on April 25, 2023, at 10:16 a.m., clinical nurse supervisor (CNS)-A stated she was responsible to provide direct	02140		

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resident cares and supervision of unlicensed staff, including dementia care training for licensee's staff.

CNS-A started employment with licensee August 19, 2022.

CNS-A's experience prior to assisted living was in long term care including nursing homes for over 30 years.

CNS-A's record lacked a completed skills competency or knowledge test required by the commissioner for a qualified dementia trainer.

On April 25, 2023, at 2:14 p.m., CNS-A and licensed assisted living director (LALD)-B stated licensee was not aware of the dementia trainer skills competency or knowledge test required by the commissioner.

Licensee's Dementia Training and Disclosure Requirements policy dated February 2, 2023, indicated "our agency provides required dementia training to all direct care staff and their supervisors and makes appropriate disclosures to clients and client representatives who request the information". The policy lacked verbiage to include dementia trainer completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.

No further information was provided.

TIME PERIOD TO CORRECT: Twenty-one (21) days

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02260	Continued From page 40	02260		
02260 SS=F	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through August 31, 2023. On April 25, 2023, at 10:30 a.m., during the entrance conference, the surveyor requested to see the licensee's dementia care training	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30688	A. BUILDING: ______ B. WING ______	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY ASSISTED LIVING LLC	10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433

(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
02260	Continued From page 41	02260		

program.

On April 26, 2023, at 11:15 a.m., after three requests, the surveyor was not provided licensee's dementia care and training program. LALD-C stated the licensee lacked a description of the dementia care program with the required content and they believed the information was removed from the contract when the licensee made a revision.

Licensee's Dementia Training and Disclosure Requirements policy dated February 2, 2023, indicated "our agency provides required dementia training to all direct care staff and their supervisors and makes appropriate disclosures to clients [residents] and client representatives who request the information".

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services | 02310

(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 standards, medical, or nursing standards for two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30688	A. BUILDING: ____ B. WING ____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY ASSISTED LIVING LLC	**10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433**

(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
02310	Continued From page 42 of two residents (R2, R7) who utilized oxygen. 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: R2 R2 was admitted to licensee on March 2, 2022, and started receiving assisted living services. R2's service agreement dated March 5, 2023, indicated R2 received services to include filling of portable oxygen tanks. On April 24, 2023, at 11:50 a.m., surveyor went to R2's apartment and observed one large and one small oxygen tank unsecured between R2's refrigerator and dresser, and one oxygen concentrator next to the living room wall. On April 24, 2023, at 11:55 a.m., RN-C confirmed R2 had oxygen tanks stored in R2's apartment. Additionally, RN-C stated oxygen tanks should be stored in a storage closet outside of resident's apartment. R7 On April 25, 2023, at 10:38 a.m., during the facility tour in the dementia care unit the surveyor observed four oxygen tanks unsecured, and two oxygen concentrators in R7's room standing by the bedside.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30688	A. BUILDING: ______ B. WING ______	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY ASSISTED LIVING LLC	**10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433**

(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
02310	Continued From page 43 On April 25, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated R7's room had four unsecured oxygen tanks. CNS-A stated the oxygen tanks were supplied by a vendor, and did not know whose responsibility it was to ensure the tanks were secured. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. Licensee's Safe Oxygen Use and Storage policy dated December 19, 2022, indicated "the RN will educate clients [residents], client's representatives and staff about the safe use and storage of oxygen. Staff will be alert to any safety concerns related to the use or storage of oxygen, will caution the client and/or the client's representative, and will take steps to eliminate the danger and notify the RN". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *04/27/23*
Time: 13:25:45
Report: 8087231085

Food and Beverage Establishment Inspection Report

Location:
Epiphany Assisted Living Llc
10955 Hanson Boulevard Nw
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0037675
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637550320
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Wash Temperature Gauge: = -- at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 188 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 3 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: CUT MELON
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: GROUND BEEF
Temperature: 32 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: HB EGG
Temperature: 32 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: BACON
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: BAKED POTATO
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER KYLE GIBB.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION

Food and Beverage Establishment Inspection Report

DATE MARKING
ALL ITEMS ON THIS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO BENARD NYANGENA, NURSE EVALUATOR II.

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 8087231085 of 04/27/23.

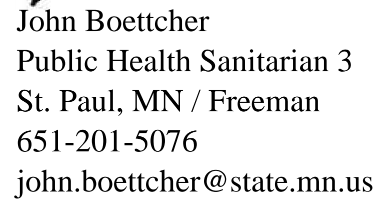
Certified Food Protection Manager:______________________

Certification Number: ______________ Expires: __/ /__________

Inspection report reviewed with person in charge and emailed.

Signed:______________________

KYLE GIBB
KITCHEN MANAGER

Signed: 

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us