Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

November 20, 2024

Licensee
Optimal Home of Richfield LLC
7621 14th Avenue South
Richfield, MN 55423

RE: Initial License Number 410726
Health Facility Identification Number (HFID) 39675
Project Number(s) SL39675015

Dear Licensee:

On October 25, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed April 24, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective November 20, 2024.**

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

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

October 2, 2024

Licensee
Optimal Home of Richfield LLC
7621 14th Avenue South
Richfield, MN 55423

RE: Provisional Conditional License Number 410726
Health Facility Identification Number (HFID) 39553
Project Number(s) SL39553015

Dear Licensee:

On August 26, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed April 24, 2024. This follow-up survey determined your facility had not corrected the state licensing orders issued pursuant to the April 24, 2024, survey.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for and additional 45-days, due to expire **November 16, 2024.**

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 (a), state correction orders issued pursuant to the last survey, completed on April 24, 2024, found not corrected at the time of the August 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on August 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to

comply with the correction orders and immediately correct any reissued orders 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

CONDITIONAL LICENSE ISSUED:
MDH will issue Optimal Home of Richfield LLC an extension to the conditional provisional assisted living facility license for 45 calendar days from the date of this notice. At an unannounced point in time, within the 45 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Optimal Home of Richfield LLC is in substantial compliance.

The following conditions will remain in effect through the extended conditional provisional license period and apply to the provisional assisted living facility license:

a. **Health Facility Construction Permit: Optimal Home of Richfield LLC** will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. **Within 14 days from the date of this notice, Optimal Home of Richfield LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority to Tim Hanna, Supervisor, at Tim.Hanna@state.mn.us.**

b. **Egress Window Requirements:** Optimal Home of Richfield LLC will replace at least one window in unoccupied sleeping room #2, meeting the minimum size requirements.

   i. Must have minimum openable width of no less than 20 inches.
   ii. Must have minimum openable height of no less than 20 inches.
   iii. Must have total openable area of no less than 248 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
   v. All measurements much be achieved under normal operation of opening window

without the use of a key, too. or special knowledge.

c. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Optimal Home of Richfield LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 45-day conditional provisional license period. If MDH determines Optimal Home of Richfield LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Optimal Home of Richfield LLC. If MDH determines Optimal Home of Richfield LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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

If you have any questions, please contact Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39675	A. BUILDING: _____ B. WING _____	R 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL HOME OF RICHFIELD LLC	7621 14TH AVENUE SOUTH 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39675015-1 On August 26, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 24, 2024. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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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	39675	A. BUILDING: _____ B. WING _____	R 08/26/2024

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OPTIMAL HOME OF RICHFIELD LLC	7621 14TH AVENUE SOUTH RICHFIELD, MN 55423

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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: Not reviewed during this survey.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}		
{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	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL HOME OF RICHFIELD LLC	7621 14TH AVENUE SOUTH RICHFIELD, MN 55423

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{0 780}	Continued From page 2 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{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: Not reviewed during this survey.	{0 800}		

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

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{0 810}	Continued From page 4	{0 810}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 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).	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 5 The findings include: INITIAL SURVEY: On April 22, 2024, at 10:00 a.m. survey staff toured the facility with house manager (HM)-C. During the tour, survey staff asked HM-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Unoccupied Sleeping Rooms: Bedroom #2: one window measuring 27.25 inches clear width, 17.5 inches clear height, and 478 square inches total open area. One window measuring 27 inches clear width, and 17.25 inches clear height, and 466 square inches total open area. Bedroom #3: one window measuring 35 inches clear width, and 16.5 inches clear height, and 577.5 inches total open area. The window in bedrooms #2 and #3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. HM-C verbally confirmed the findings.	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 6 During interview on April 23, 2024, at 11:00 a.m. HM-C stated he understood the window requirements and would ensure each bedroom had an egress compliant window. FOLLOW UP SURVEY On August 26, 2024, at 11:15 a.m., on a tour of the facility with unlicensed personnel (ULP)-A, the surveyor asked ULP-A to open the windows in the resident bedrooms for measurement. The measurements were as follows: Unoccupied Sleeping Rooms: Bedroom #2: one window measuring 27.25 inches clear width, 20.5 inches clear height, and 553.5 square inches total open area. One window measuring 27.25 inches clear width, and 18.25 inches clear height, and 497.3 square inches total open area. Bedroom #2's windows remained non-compliant. Bedroom #3: one window measuring 35 inches clear width, and 20.5 inches clear height, and 717.5 inches total open area. Bedroom #3's window was compliant. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On August 26, 2024, at 11:47 a.m., in an interview, HM-C stated that an outside contractor had modified the windows in unoccupied bedrooms #2, and #3 to meet licensing standards.	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 7 On August 26, 2024, at 11:52 a.m., the surveyor measured windows with HM-C to verify findings. On August 26, 2024, at 11:55 a.m., in a phone interview, contractor (C)-D stated that they had adjusted the windows in the facility so that they met requirements, and that no windows in the facility had been physically replaced. C-D stated they were under the assumption that windows openings were required to be minimum of 20 inches tall, and 20 inches wide. C-D stated they were unaware that windows needed to have a minimal opening area of 648 square inches. No further information was provided.	{0 820}		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01730}	Continued From page 8 medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01880}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

June 7, 2024

Licensee
Optimal Home of Richfield LLC
7621 14th Avenue South
Richfield, MN 55423

RE: Provisional Conditional License Number 410726
Health Facility Identification Number (HFID) 39675
Project Number(s) SL39675015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90 days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 5, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $500.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

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.

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

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

The following conditions apply on the conditional provisional assisted living facility license:

a. **Health Facility Construction Permit: Optimal Home of Richfield LLC** will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect Sate Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Optimal Home of Richfield LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor: Optimal Home of Richfield LLC** must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email within two (2) weeks of the date of this notice:

   i. Name

   ii. License Number

   iii. Contact Information

c. **Egress Window Requirements:** Optimal Home of Richfield LLC will replace at least one window in unoccupied sleeping room #2 and unoccupied sleeping room #3, meeting the minimum size requirements.

   i. Must have minimum openable width of no less than 20 inches.
   ii. Must have minimum openable height of no less than 20 inches.
   iii. Must have total openable area of no less than 248 square inches (4.5 square feet).
   iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
   v. All measurements much be achieved under normal operation of opening window without the use of a key, too. or special knowledge.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Optimal Home of Richfield LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Optimal Home of Richfield LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Optimal Home of Richfield LLC. If MDH determines Optimal Home of Richfield LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after

provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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

If you have any questions, please contact Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39675	A. BUILDING: _____ B. WING _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMAL HOME OF RICHFIELD LLC	7621 14TH AVENUE SOUTH 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 the Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39675015-0 On April 22, 2024, to April 24, 2024, 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 two residents, all of whom received services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 had the potential to affect all residents of 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on April 22, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 10:40 a.m., during the facility tour with house manager (HM)-C, the surveyor observed the facility was a rambler style home which included a main floor and a basement. The upstairs bathroom lacked paper towels for hand drying. The upstairs bathroom had a hand towel/washcloth, soaking wet, on the	0 510		

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0 510	Continued From page 3 bathroom vanity. The surveyor observed the downstairs bathroom lacked paper towels for hand drying. The downstairs bathroom had hand towels which were damp. On April 22, 2024, at 12:23 p.m., the surveyor observed the upstairs bathroom lacked paper towels for hand drying. The wet hand towel/washcloth remained on the bathroom vanity. The surveyor observed the downstairs bathroom lacked paper towels and contained damp hand towels for hand drying. On April 23, 2024, at 9:35 a.m., the surveyor observed the upstairs bathroom lacked paper towels for hand drying. The wet hand towel/washcloth remained on the bathroom vanity. The surveyor observed the downstairs bathroom lacked paper towels and contained damp hand towels for hand drying. On April 24, 2024, at 12:13 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated they were supposed to have paper towels for hand drying, they stated they must have been out of them. RN/LALD-A stated hand towels were an infection risk. The licensee's Hand Hygiene Policy and Procedure dated August 1, 2023, indicated: "Hand washing Procedure: 1. Stand away from the sink. 2. Turn on faucet to a comfortable temperature (do not use scalding hot water). 3. Wet hands and wrists. 4. Dispense soap and apply to hands and wrists. 5. Scrub palms, back of hands, between fingers, under fingernails, and wrists for at least 20 seconds. 6. Rinse hands and wrists under water (do not	0 510		

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0 510	Continued From page 4 "flick" hands or fingers) (do not shut off the water). 7. Dry hands with a clean paper towel and discard in the appropriate receptacle. 8. Take a new, clean paper towel, use it to shut off the faucet, and discard in the appropriate receptacle. 9. If leaving a bathroom, use a new paper towel to open the door and discard the paper towel in the appropriate receptacle upon exiting the bathroom." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 5 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 functioned and are interconnected so the 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 April 22, 2024, at 10:30 a.m., survey staff toured the facility with house manager (HM)-C. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom #1 smoke alarm sounded when tested, but was not interconnected with the other smoke alarms in the facility. 2. Bedroom #2 smoke alarm sounded when tested, but was not interconnected with the other	0 780		

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0 780	Continued From page 6 smoke alarms in the facility. 3. Bedroom #3 smoke alarm sounded when tested, but was not interconnected with the other smoke alarms in the facility. 4. Bedroom #4 did not have a smoke alarm installed. 5. Bedroom #5 did not have a smoke alarm installed. 6. The smoke alarm in the living room was not interconnected with the other smoke alarms in the facility. During interview on April 23, 2024, at 11:00 a.m., HM-C stated they understood the requirement for the smoke alarms and would get them interconnected. 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, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to	0 800		

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0 800	Continued From page 7 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). The findings include: On April 22, 2024, at 10:30 a.m., survey staff toured the facility with house manager (HM)-C. It was observed that an exterior-mounted snow shield was installed over the window well of bedroom #4 so that it was obstructing the egress window from opening completely to allow for egress. The snow shield had an overgrown bush adjacent to it that prohibited the snow shield from opening. It was observed that the stairwell to the basement had a fire exit sign attached to the ceiling. There was not an exit from the facility in the basement. Exit signage should only be installed in the path of egress, any other posted exit signs would confuse residents, staff, and visitors in an emergency. During interview on April 23, 2024, at 11:00 a.m., HM-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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

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0 810	Continued From page 9 licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 23, 2024, consultant (C)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated 01/01/2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should	0 810		

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0 810	Continued From page 10 follow in case of a fire or similar emergency. "Emergency Preparedness Plan: Handout for Residents", undated, from the "grab and go" binder indicated that residents should wait for instructions from the caregiver, but the handout did not include specific instructions for residents who are capable of assisting in their own evacuation. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During interview, C-D stated that they had a "grab and go" binder that included instructions to staff on how to assist residents in an emergency. "Resident Profile", dated 04/23/2024, from the "grab and go" binder included the following language: "Evacuation Status: Level 2 - Resident who is ambulatory, requires moderate nursing care and requires assistance in evacuation." The resident profile did not include specific instructions to staff for resident movement, evacuation, or relocation. During an interview on April 23, 2024, at 11:00 a.m., C-D stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. C-D stated they had a "grab and go" binder that included more information on the deficient areas of their policy. Additional documentation was received on April 23, 2024 at 3:20 p.m. The contents of the "Grab and Go" binder were reviewed and included in this summary.	0 810		

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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
0 810	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 pattern scope (when more than a limited number of residents are affected, more	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39675	A. BUILDING: _____ B. WING _____	04/24/2024

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OPTIMAL HOME OF RICHFIELD LLC	7621 14TH AVENUE SOUTH 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
0 820	Continued From page 12 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 22, 2024, at 10:00 a.m. survey staff toured the facility with house manager (HM)-C. During the tour, survey staff asked HM-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Unoccupied Sleeping Rooms: Bedroom #2: one window measuring 27.25 inches clear width, 17.5 inches clear height, and 478 square inches total open area. One window measuring 27 inches clear width, and 17.25 inches clear height, and 466 square inches total open area. Bedroom #3: one window measuring 35 inches clear width, and 16.5 inches clear height, and 577.5 inches total open area. The window in bedrooms #2 and #3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying	0 820		

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0 820	Continued From page 13 bedroom for resident occupancy. HM-C verbally confirmed the findings. During interview on April 23, 2024, at 11:00 a.m. HM-C stated he understood the window requirements and would ensure each bedroom had an egress compliant window. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 820		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 14 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to identify how a resident's medications would be stored, who would monitor medication supplies, and who would reorder medication for one of two residents (R2). Further, the licensee failed to follow the resident's individualized medication management plan to ensure resident's prescribed medications and orders were current and accounted for after a provider appointment 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 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).	01730		

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01730	Continued From page 15 The findings include: R2 was admitted to the licensee on April 4, 2024, with diagnoses of suicidal ideations, major depressive disorder, and paranoid schizophrenia. R2's Service Plan dated April 4, 2024, indicated R2 received medication management services and behavior management and indicated, "If medication management services are desired, the registered nurse or licensed health professional shall conduct an assessment to determine what medication management service will be provided and how that service will be provided. This assessment will be conducted face-to-face with the resident. The assessment will include an identification and review of all medications the resident is known to be taking and shall include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. The Assisted Living requires a prescriber order for all medications managed or administered by our staff, including over-the-counter medications and dietary supplements." R2's 14-Day Assessment dated April 17, 2024, indicated staff administered medications and self-administration of medications was not applicable. The assessment indicated the registered nurse (RN) needed to consult and clarify instruction and changes from medical providers. R2's record and Order Summary Report signed by R2's provider on April 3, 2024, lacked a prescription for tamsulosin. R2's record lacked documentation of how R2's	01730		

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01730	Continued From page 16 medications would be stored, who would monitor medication supplies, and who would conduct prescription medication refills. On April 22, 2024, during the facility tour with house manager (HM)-C, the surveyor observed R2's room which contained a Walgreens prescription medication bottle labeled with R2's name. The bottle was filled with a half white and green capsule with 0.4 mg (milligrams) and ZA-18 stamped on them. The bottle indicated the following: -tamsulosin, 0.4 milligrams (mg) capsule, take one capsule by mouth daily after a meal, filled on April 17, 2024. On April 22, 2024, at 12:10 p.m., unlicensed personnel (ULP)-B stated they were instructed by the nurse to report any medications they found in a resident's room to the nurse. On April 22, 2024, at 1:22 p.m., house manager (HM)-C and RN/licensed assisted living director (RN/LALD)-A stated they were unaware R2 had bottles of medication in their room. Both stated R2 was not safe to self-administer their own medications. On April 23, 2024, at 8:49 a.m., ULP-B stated R2 did not self-administer medication. ULP-B stated R2 did not have scheduled medications and only had as needed (PRN) medications administered by staff. ULP-B stated they were unaware R2 had bottles of medication in their room. On April 23, 2024, at 9:04 a.m., HM-C stated they were looking into how R2 got the tamsulosin. HM-C stated they did not know about the medications until the surveyor told them they were there. HM-C stated R2 recently had a	01730		

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01730	Continued From page 17 medical appointment with their provider, he returned from the appointment without paperwork. They stated R2's father (F)-E brought him to and from the appointment. On April 24, 2024, at 8:45 a.m., ULP-B and HM-C stated they discussed the tamsulosin found in R2's room with R2. R2 stated they got it at their last appointment. HM-C stated R2 gave the medication to staff so they could administer it for R2. ULP-B and HM-C stated they were trying to reach R2's pharmacy and were working on getting a prescription from R2's provider. On April 24, 2024, at 9:27 a.m., ULP-B and HM-C stated R2's provider appointment in question was on April 17, 2024, which was the same day the tamsulosin pill bottle indicated the prescription was filled on. On April 24, 2024, at 12:13 p.m., RN/LALD-A stated they did follow up with R2 and F-E after the appointment on April 17, 2024, and both R2 and F-E stated they did not have any paperwork or medications. RN/LALD-A stated staff were trained to notify the nurse immediately if they find medications in a resident's room. RN/LALD-A stated they did not follow up with R2's clinic after the appointment. RN/LALD-A stated it was the nurse's responsibility to follow up with a resident's clinic after an appointment. RN/LALD-A stated R2's medication management plan should have indicated how their medication would be stored and who would order refills for medications. The licensee's Coordination in the Medication Management Plan policy dated January 1, 2023, indicated, "The RN is responsible for coordinating the Medication Management Program with other health care providers, including the primary care	01730		

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01730	Continued From page 18 provider and pharmacist, serving the resident." It further indicated, "When any staff member of [licensee] becomes aware of any medication or dietary supplement being used by the resident that was not included in the assessment for medication management services, the staff member will advise the Registered Nurse (RN) and document this in the clinical record." The licensee's Medication Supply policy dated January 1, 2023, indicated: "The medication management plan** will identify who is responsible for monitoring medication supplies and ensuring refills are ordered/timely. Should medications/supplies not be obtained as needed, the RN will complete the following. a. Discuss the discrepancy with the resident and/or resident ' s representative(s) or person identified in the medication management plan as responsible for reordering/obtaining refills in a timely manner. b. Coordinate with the pharmacy to obtain/maintain a back-up supply of medications. c. Revise the medication management plan regarding who is responsible for assuring an adequate supply of medications for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01730		
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.	01880		

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01880	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for one of one resident (R1) with refrigerated medications. 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: R1 was admitted to the licensee on December 6, 2023, and had a diagnosis of type two diabetes. R1's Service Plan dated March 25, 2024, indicated R1 received medication administration services. On April 23, 2024, at 8:37 a.m., the surveyor observed the licensee's medication refrigerator with unlicensed personnel (ULP)-B in the dining room. The round classic thermometer inside the refrigerator read 28 degrees Fahrenheit (F). The refrigerator contained the following insulin pens with pharmacy labels for R1: -Basaglar (insulin glargine) 100 unit (u)/milliliter (ml), 3 ml KwikPen, 2 u as needed to prime pen before each dose, inject 23 u subcutaneously (SQ) every morning; and -insulin aspart (Novolog) 100 u/ml, 3 ml Prefilled	01880		

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01880	Continued From page 20 FlexPen, 2 u as needed to prime pen before each dose, inject 5 u SQ three times daily before meals plus sliding scale: 150-200=1 u, 201-250=2 u, 251-300=3 u, 301-350=4 u. The licensee's refrigerator temperature log for 2024, indicated the refrigerator temperature should be kept between 36-46 degrees F. During the months of January through April 23, 2024, the refrigerator temperature was below 36 degrees F on the following dates: -January 1-6, 11, 17-19, 23, 24, 28 and 31. Of these dates, one was below freezing (32 degrees F); -February 1, 3, 5-10, 15, 17, 18, 21, 24 and 28. Of these dates, three were below freezing; -March 1, 3-5, 7-9, 11, 14, 15, 17, 19, 20, 23-25, 28 and 31. Of these dates, four were below freezing; and -April 2, 4, 7, 11, 15, 17-20 and 23. Of these dates, one was below freezing. R1's April 2024, Med Admin Summary form, or medication administration record (MAR), indicated R1 received the above-mentioned insulins on April 1 through 22, 2024. On April 23, 2024, at 8:37 a.m., ULP-B stated anyone was allowed to check the medication refrigerator temperature and document it on the temperature log. ULP-B stated the temperature should be checked daily, they checked today, April 23, 2024, and the temperature was 34 degrees F. ULP-B stated if there was a temperature outside of the required temperature range on the temperature log, they should notify the nurse. ULP-B stated the licensee currently administered insulin for R1. On April 24, 2024, at 12:13 p.m., registered	01880		

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01880	Continued From page 21 nurse/licensed assisted living director (RN/LALD)-A stated they were not fully aware of the temperature requirements for R1's insulins. RN/LALD-A stated it was a newer refrigerator and must be running cold and should be adjusted. RN/LALD-A stated they monitored the temperature log themselves. RN/LALD-A stated staff should notify them if the temperature falls outside of the defined temperature range on the temperature log so they could make temperature adjustments. RN/LALD-A stated they will need to reevaluate the required temperature of the medication refrigerator. The licensee's Storage/Control of Medications policy dated January 3, 2021, indicated, "Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." Manufacturer instructions for Novolog (insulin aspart) FlexPen, last revised in February 2023, indicated to store unused FlexPens in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. Manufacturer instructions for Basaglar (insulin glargine) KwikPen, last revised in November 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *04/22/24*
Time: 12:50:30
Report: 1004241093

Food and Beverage Establishment Inspection Report

Location:
Optimal Home of Richfield LLC
7621 14th Ave S
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0042569
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO SMALL DIAMETER PROBE THERMOMETER ON SITE. PROVIDE AND MAINTAIN.

Comply By: 04/29/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: > at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: POTATO SALAD
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR
Violation Issued: No

Type: Full
Date: *04/22/24*
Time: 12:50:30
Report: 1004241093
Optimal Home of Richfield LLC

Food and Beverage Establishment Inspection Report

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY JOEY KEEN.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-PREVENTING BAREHAND CONTACT
-HANDWASHING
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE STAFF ON SITE, THE CERTIFIED FOOD PROTECTION MANAGER OVER THE PHONE, AND WITH THE NURSE EVALUATOR, JOEY.

*FLOORS ARE VINYL TILE, WALLS ARE PAINTED DRYWALL AND TILE BACK SPLASH, AND CEILING IS SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE SOLID AND SEALED STONE AND CABINETS ARE VARNISHED PAINTED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

.
*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *04/22/24*
Time: 12:50:30
Report: 1004241093
Optimal Home of Richfield LLC

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 1004241093 of 04/22/24.

Certified Food Protection Manager: AWIL AMBASHE

Certification Number: FM122346 Expires: 02/18/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
AWIL AMBASHE

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us