



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 1, 2025

Licensee

Triple Angels Healthcare
7150 West Point Douglas Road South
Cottage Grove, MN 55016

RE: License Number 417728
Health Facility Identification Number (HFID) 34363
Project Number(s) SL34363016

Dear Licensee:

On August 19, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed February 6, 2025. 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 October 1, 2025.

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.

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,

A handwritten signature in black ink that reads '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

AMENDED

Electronically Delivered

July 15, 2025

Licensee

Triple Angels Healthcare

7150 West Point Douglas Road South

Cottage Grove, MN 55016

RE: Project Number(s) SL34363016

Dear Licensee:

Please note: This letter amends the previous letter dated March 10, 2025. Specifically, following the results of the informal conference and Stipulated Agreement, the original fines were rescinded. As a result of the rescinded penalties, language related to the fines imposed were also removed from this notice. Further, your right to request a reconsideration has expired with the previous notice dated March 10, 2025.

The Minnesota Department of Health (MDH) completed a survey on February 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 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 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>

INFORMAL CONFERENCE

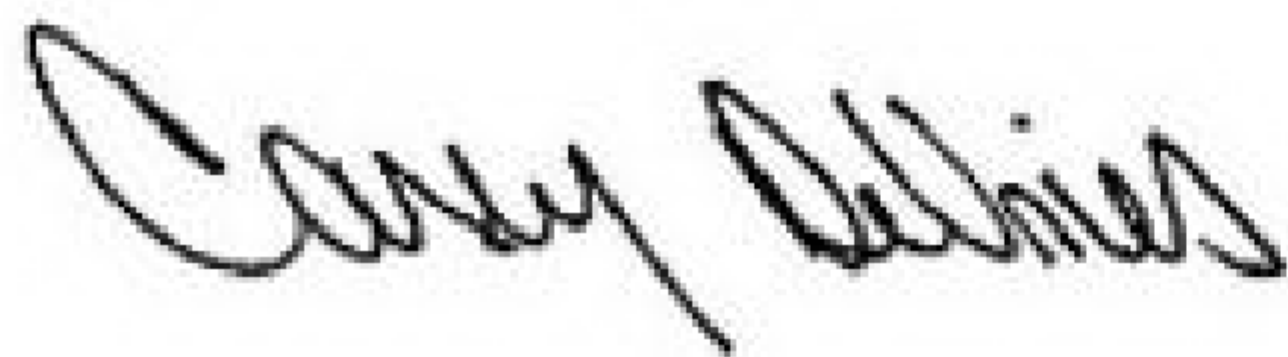
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Triple Angels Healthcare. Please contact Casey DeVries at 651-201-5917 on or before **March 13, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 10, 2025

Licensee

Triple Angels Healthcare

7150 West Point Douglas Road South

Cottage Grove, MN 55016

RE: Project Number(s) SL34363016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 1310 - 144g.60 Subd. 3 - Licensed Health Professionals And Nurses - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$12,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

INFORMAL CONFERENCE

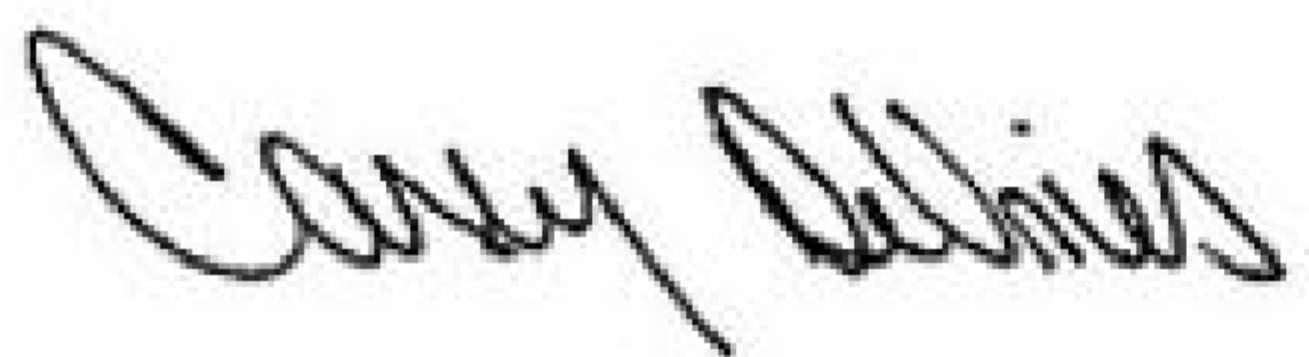
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Triple Angels Healthcare. Please contact Casey DeVries at 651-201-5917 on or before **March 13, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016			
(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 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: SL34363016-0 On February 3, 2025, through February 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were eight resident(s); eight receiving services under the Assisted Living Facility with Dementia Care license. Immediate correction orders were identified on February 4, 2025, issued for SL34363016-0, tag identification 0495, 1290, and 1310.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130			

Minnesota Department of Health

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130			

Minnesota Department of Health

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130			

Minnesota Department of Health

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the provisional licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals with no assisted living contracts residing at the location. 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's assisted living licensure effective date was November 1, 2024, with an expiration date of October 31, 2025. On February 3, 2025, at 10:06 a.m., administrator (A)-A stated the licensee had a current census of 8 residents. On February 4, 2025, at 12:14 p.m., the surveyor received an email from the environmental engineer completing on site survey observations. The email contained multiple images of room 103 which was not listed as being occupied by a	0 130			

Minnesota Department of Health

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0 130	Continued From page 5 resident in the licensee's undated document titled Room & Suite Listing which served as a room directory for the facility. The document indicated the room as "Sleep Overnight". On February 5, 2025, at 9:35 a.m., the surveyor entered room 103 to verify images sent by the environmental engineer. The surveyor observed a pair of knee-high boots near the doorway. The room was separated into two separate living spaces by a curtain. Each side of the living spaces had a full sized, non-medical, consumer grade mattress. Both closets in the room were filled with women's clothing hanging on hangers, stuffed into bags, and piled up on the top shelf of the closet. On one of the dressers, there were multiple bottles of medications prescribed to unlicensed personnel (ULP)-I as well as food items and personal effects. The surveyor observed a letter addressed to ULP-F from a health insurance provider. The address on the letter was the facility address. The surveyor observed multiple trash bags filled with clothing as well as multiple sets of women's shoes next to one of the full-sized mattresses. While documenting items found in the room, the surveyor observed ULP-I sleeping on the far side of the room. The employee roster provided by the licensee did not include ULP-I and indicated ULP-F was hired in August of 2023. On February 5, 2025, at 9:52 a.m., ULP-I stated they worked as a volunteer at the facility, but they lived in Brooklyn Park. ULP-I stated all the clothing, shoes, and mattress belonged to her. ULP-I stated they did not drive, so they used the room to rest between shifts.	0 130			

Minnesota Department of Health

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0 130	Continued From page 6 On February 5, 2025, at 10:09 a.m., ULP-F stated they stayed on site between shifts in room 103. ULP-F stated they currently lived in North Minneapolis with their sister. ULP-F stated the reason they had mail delivered to the facility was due to them just moving from Arizona and because they had difficulty getting their address changed at the post office. ULP-F stated some of the belongings in the room belonged to them. On February 5, 2025, at 1:52 p.m., in a phone conference, administrator (A)-A stated room 103 was used as overnight lodging for staff. A-A stated one staff member would sleep, another would remain awake, and if the awake staff needed help, they would wake the sleeping staff. On February 5, 2025, at 1:53 p.m., in a phone conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated staff stayed in room 103 for up to week at a time. On February 5, 2025, at 1:54 p.m., A-A stated they were aware staff were having their mail delivered to the facility. A-A stated it was an ongoing issue with staff. On February 5, 2025, at 2:00 p.m., A-A stated the clothing in room 103 belonged to them. On February 5, 2025, at 2:01 p.m., LALD/CNS-B stated staff had gotten carried away with brining in their personal belongings into the facility, and it would be resolved. Additionally, LALD/CNS-B stated staff were dedicated to their work and saw the facility as a home. No further information was provided.	0 130			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
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0 130	Continued From page 7	0 130			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to take corrective actions related to a citation issued on August 31, 2022, for failing to provide smoke alarms in resident sleeping rooms. The lack of action to	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016		
(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
0 340	Continued From page 8 ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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 February 4, 2025, at 11:30 a.m., the surveyor entered and toured the facility with the administrator (A)-A. During the tour, the surveyor observed smoke alarms were not installed in all resident sleeping rooms. A fire alarm horn strobe tied into the fire alarm system was installed, but the smoke detection system was not installed in resident rooms. On February 4, 2025, at 12:00 p.m., A-A stated the installed fire alarm horn was detecting smoke, and the inspection report, which can describe the function, would be provided via email as a follow-up. However, no follow-up email was received from the facility. On February 5, 2025, at 1:50 p.m., during a phone interview, A-A stated the horn did not detect smoking and confirmed a smoke alarm was not installed in the resident sleeping rooms. On February 6, 2025, at 3:00 p.m., during a phone interview, A-A stated he was not aware of the previously issued citation for failing to provide	0 340			

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0 340	Continued From page 9 smoke alarms in resident sleeping rooms and verified the facility failed to take corrective actions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 420			

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0 420	Continued From page 10 a large portion or all of the residents). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the	0 420			

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0 420	Continued From page 11 facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window) and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page six was electronically signed by the owner on July 18, 2024. The licensee had an assisted living with dementia care license, effective August 1, 2021. As a result of this survey, the following orders were issued under 0130, 0340, 0480, 0485, 0495, 0500, 0550, 0630, 0650, 0680, 0730, 0775, 0780, 0790, 0810, 0900, 0970, 1290, 1310, 1370, 1380, 1460, 1540, 1610, 1620, 1640, 1750, 1880, 2040, 2310, and 2370, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

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0 480	Continued From page 12 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

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0 480	Continued From page 13 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 14	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living package fee. Additionally, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the facility. 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	0 485			

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0 485	Continued From page 15 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's rental agreement provided to residents to sign at the time of admission, indicated the licensee would provide the resident with three meals per day plus snacks, which would be included in the basic daily fee. R2, R3, R4, R5, and R9's records all lacked documentation of a contract being executed prior to being provided assisted living services. No contracts were found in the resident records. On February 3, 2025, at 10:06 a.m., during a tour of the facility, the surveyor was unable to locate a posted menu prepared at least on week in advance. On February 6, 2025, at 3:38 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were aware their contract containing meals and stated their contract had always contained meals in their basic daily fee. LALD/CNS-B stated they did not understand why their contract could not contain meals, and "I'm hearing this for the first time that we cannot include meals in the contract". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			

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0 495	Continued From page 16	0 495			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) was readily available for consultation to the staff performing delegated nursing tasks and services 24-hours a day, seven days per week. This had the potential to affect all eight residents receiving services under the Assisted Living Facility with Dementia Care license. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 10:00 a.m., during the entrance conference, administrator (A)-A stated the licensee provided on call nursing services 24 hours a day, and in the event of a change of condition, the nurse would be expected to come into the facility to complete assessments. During the entrance conference A-A provided the licensee's employee list. The employee list indicated RN-E was working for the licensee as a RN.	0 495			

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0 495	Continued From page 17 RN-E was hired August 7, 2024, by the licensee to provide clinical oversight and supervision of unlicensed personnel. On February 4, 2025, at 9:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were currently out of the country and RN-E was responsible for clinical oversight during their absence. On February 4, 2025, at 11:58 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board issues the following Order: 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." On February 4, 2025, at 1:12 p.m., RN-E stated LALD/CNS-B had been out of the country since December 20, 2024, and during the absence of LALD/CNS-B, they had overseen all tasks of the clinical nurse supervisor. RN-E stated they were responsible for all assessments of residents and supervision of unlicensed personnel in addition to verifying and transcribing orders from resident's medical providers. RN-E stated they expected LALD/CNS-B to return from Nigeria by the end of the month. Additionally, RN-E stated they were also from Nigeria, and flight time from Nigeria to the United States was around 15 hours, which indicated there would be no way for LALD/CNS-B	0 495			

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0 495	Continued From page 18 to be able to return in a timely manner to complete an assessment. On February 4, 2025, at 1:28 p.m., A-A stated they were not aware RN-E's nursing license had been revoked. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or	0 500			

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0 500	Continued From page 19 exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. 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 February 4, 2025, at approximately 12:45 p.m., administrator (A)-A provided the surveyor with a binder containing the licensee policies and procedures. A-A stated the binder contained all policies and procedures related to day-to-day	0 500			

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0 500	Continued From page 20 operations within the facility. The licensee failed to provide the following policies and procedures during or after the survey process: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; and, - orientation to and implementation of the assisted living bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult	0 550			

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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
0 550	Continued From page 21 Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 10:06 a.m., during a tour of the facility, the surveyor observed the common areas shared by residents, staff, and visitors, contained a posting of the licensee's grievance procedure. This posting lacked the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	0 550			

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0 550	Continued From page 22 On February 3, 2025, at 11:25 a.m., administrator (A)-A stated the licensee's grievance forms that are provided to residents to fill out in the event of a complaint are stored in the nurse's station. If a resident had a complaint, they would have to ask for a form from staff. On February 6, 2025, at 3:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated the licensee held monthly resident meetings where residents are encouraged to convey their grievances in a group setting. Additionally, LALD/CNS-B stated they were unaware of the requirement for contact information for the individuals who are responsible for handling resident grievances was required to be included on the posted grievance form. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure would be conspicuously posted in the residence with the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630			

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0 630	Continued From page 23 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for five of eight residents (R2, R4, R6, R8, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide	0 630			

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0 630	Continued From page 24 documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R2's IAPP dated December 27, 2024, indicated R2 was at risk to being abused by others, but lacked an IAPP to include: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4 R4 was admitted the licensee on March 19, 2017, and began receiving assisted living services on August 1, 2021. R4's diagnosis included schizo-affective disorder, chronic obstructive pulmonary disease, panic disorder, and post-traumatic stress disorder. R4's undated and unsigned service plan indicated R4 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility, medication administration, behavior management, housekeeping and linen changes. R4's IAPP dated November 27, 2024, indicated R4 was at risk to being abused by others, but lacked an IAPP to include:	0 630			

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0 630	Continued From page 25 - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R6 R6 was admitted to the licensee on May 17, 2016, and began receiving assisted living services on August 1, 2021. R6's diagnosis included encephalopathy, Wernicke's, cancer of the endometrium, adenocarcinoma stage 1, and muscle weakness. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R6. R6's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R6 received assistance with dressing, medication setup, laundry, housekeeping, vital signs, grooming assistance, incontinence care and linen changes. R6's IAPP dated November 15, 2024, indicated R6 was at risk to being abused by others, but lacked an IAPP to include: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse other vulnerable adults. R8 R8 was admitted to the licensee on January 29, 2020, and began receiving assisted living services on August 1, 2021.	0 630			

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0 630	Continued From page 26 R8's diagnosis included Huntington's disease and history of alcohol abuse. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R8. R8's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R8 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, assistance with drinking, skin care, vital signs, linen changes, escort and mobility assistance, transfer assistance, and supervision of special diets. R8's IAPP dated November 17, 2024, contained contradictory assessment information. R8's IAPP included the following language: - Resident is not at risk to be abused; Client is under 24/7 close monitoring and supervision. - Resident is at risk to be abused (physically, verbally, emotionally, finically, and/or sexually), specify measures to minimize risk: No. Additionally, R8's IAPP lacked the following required information: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R9 R9 was admitted to the licensee on August 28, 2023, to receive assisted living services. R9's diagnosis included schizophrenia and Parkinson's disease. R9's unsigned service plan dated January 4,	0 630			

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0 630	Continued From page 27 2024, indicated R9 received standby assistance with activities, setup assistance with bathing, setup assistance with dining, activity reminders, assistance with shopping, assistance with transportation, assistance with TED hose, case management, bed making, housekeeping, personal laundry, medications setup, medication administration, behavior management, and safety checks. R9's IAPP dated January 3, 2025, contained contradictory assessment information. R9's IAPP included the following language: - Resident is not at risk to be abused; - Resident is at risk to be abused (physically, verbally, emotionally, finically, and/or sexually), specify measures to minimize risk: No. Additionally, R9's IAPP lacked the following required information: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On February 6, 2025, at 3:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they thought all required components had been documented in the resident's IAPPs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650			

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0 650	Continued From page 28 each paid staff member, 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 contained the required content for two of two employees (unlicensed personnel (ULP)-C, ULP-F). 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	0 650			

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0 650	Continued From page 29 a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at approximately 10:30 a.m., administrator (A)-A stated they were aware of the required content in the employee records. On February 5, 2025, at 1:07 p.m., A-A provided employee records and stated the records provided were complete in their contents. ULP-C ULP-C was hired February 24, 2024, to provide assisted living services. ULP-C's record lacked documentation of a job description. ULP-F ULP-F was hired August 28, 2023, to provide assisted living services. ULP-F's employee record lacked documentation of a job description and annual performance reviews. On February 6, 2025, at 3:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they had some records on paper, and some on the computer. LALD/CNS-B stated they thought the required documents may be stored in their computer. The licensee lacked policy and procedure related to employee records. No further information was provided.	0 650			

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0 650	Continued From page 30	0 650			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 31 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 February 3, 2025, at approximately 11:10 a.m., the surveyor retrieved the licensee's EPP from administrator (A)-A who stated the EPP was stored in the front administration office of the facility. A-A stated the office was locked outside of normal business hours. The licensee's undated EPP lacked evidence of the following required content: - annual review; - quarterly review of missing resident policy; - a written risk assessment utilizing an all-hazards approach; - categorization of probable risks by likelihood of occurrence; - written strategies addressing facility and community-based risks; - missing resident plan; - policies and procedures to identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - policies and procedures to identify a process for cooperation and collaboration with local, tribal, regional, state and federal EP to maintain integrated response; - development and implementation of policies and	0 680			

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0 680	Continued From page 32 procedures based on EP, risk assessment and communication plan; - policies and procedures for subsistence needs for staff and residents; - policies and procedures to address needs for staff and residents whether evacuated or sheltered in place; - policies and procedures for food, water, medical supplies and pharmaceutical supplies; - policies and procedures for the safe/sanitary storage of provisions; - policies and procedures for tracking staff and patients; - policies and procedures for medical documents; - policies and procedures to maintain medical documentation, resident information, protects confidentiality, and secures/maintains the availability of records; - policies and procedures for volunteers; - policies and procedures addressing the development and documentation of arrangements with other facilities and providers to receive residents in the event of limitations/cessation of operation to maintain the continuity of services to residents; - roles under wavier declared by secretary; - policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - development of communication plan; - names and contact information of staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - emergency officials contact information; - policies and procedures including primary and alternate means of communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies; - policies and procedures which cover methods for sharing information; and	0 680			

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0 680	Continued From page 33 - policies and procedures on sharing information on occupancy needs. On February 6, 2025, at 3:42 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated the licensee's EPP was stored behind locked doors. LALD/CNS-B stated the licensee used a consultant agency and received annual updates on their EPP from them. LALD/CNS-B was unaware the licensee's current EPP had not been customized to the facility. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730			

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0 730	Continued From page 34 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a discharge summary for one of one discharged resident (R1).	0 730			

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0 730	Continued From page 35 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 discharged from the licensee on August 27, 2024. R1's record lacked a discharge summary. On February 6, 2025, at 3:52 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated R1 only resided at the facility for around two weeks, and an admission was never completed on the resident, although the licensee did provide services and medications to R1 while they resided within the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 775			

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NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016		
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0 775	Continued From page 36 licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide sprinkler system inspection records, smoke alarm inspection records, and generator maintenance records. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, at 11:30 a.m., the surveyor reviewed the maintenance record and conducted an interview with administrator (A)-A. The surveyor requested the sprinkler system inspection records, smoke alarm inspection records, and generator maintenance records for review. No inspection records were provided. On February 4, 2025, at 12:00 p.m., A-A stated the facility could not locate the inspection records and could not provide any record of the annual inspections. A-A stated that the documentation would be provided via email as a follow-up, but no documentation has been provided by follow-up email. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			

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0 780	Continued From page 37	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a smoke alarm in all resident sleeping rooms. This deficient condition 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 cause serious injury, impairment, or death), and	0 780			

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0 780	Continued From page 38 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 February 4, 2025, at 11:30 a.m., the surveyor entered and toured the facility with administrator (A)-A. During the tour, the surveyor observed smoke alarms were not installed in all resident sleeping rooms. A fire alarm horn strobe tied into the fire alarm system was installed, but the smoke detection system was not installed in resident rooms. On February 4, 2025, at 12:00 p.m., A-A stated the installed fire alarm horn was detecting smoke, and the inspection report, which can describe the function, would be provided via email as a follow-up. However, no follow-up email was received from the facility. On February 5, 2025, at 1:50 p.m., during a phone interview, A-A verbally confirmed the horn did not detect smoke and confirmed a smoke alarm was not installed in the resident sleeping rooms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790			

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0 790	Continued From page 39 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required for the facility. This had the potential to affect all current 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 February 4, 2025, at 11:30 a.m., the surveyor entered and toured the facility with administrator (A)-A. During the tour, the surveyor observed the portable fire extinguishers were tagged, showing the required annual service but no records were made available to the surveyor to verify the required monthly visual inspections were performed or recorded for portable fire extinguishers. On February 4, 2025, at 12:00 p.m., A-A confirmed that the required monthly inspections had not been completed on the fire extinguishers.	0 790			

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0 790	Continued From page 40	0 790			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with the required content, to make the FSEP readily accessible, to provide the required training, and to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 February 4, 2025, at 12:30 p.m., the surveyor conducted an interview with administrator (A)-A on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On the facility tour with A-A on February 4, 2025, at 11:30 a.m., the surveyor observed the posted evacuation plans did not show the location and number of resident rooms. 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	0 810			

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0 810	Continued From page 42 emergency, including individualized, unique needs of residents. The plan failed to include ways to move and evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. Record review of the FSEP indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. On February 4, 2025, at 1:00 p.m., A-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. On February 4, 2025, at 1:00 p.m., A-A stated the licensee provided annual emergency preparedness training to employees and confirmed the training did not include the facility-specific fire safety and evacuation contents. A-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that the drills were conducted on 5/1/24, 5/3/24, 5/23/24, 6/21/24, and 1/24/25, with no further drills being documented.	0 810			

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0 810	Continued From page 43 On February 4, 2025, at 1:00 p.m., A-A stated the facility did conduct evacuation drills every other month and verified there were no further documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	0 900			

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0 900	Continued From page 44 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for five of eight residents (R2, R3, R4, R5, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee converted to an Assisted Living Facility with Dementia Care license on August 1, 2021. R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide	0 900			

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0 900	Continued From page 45 documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R3 R3 was admitted to the licensee on June 14, 2019, and began receiving assisted living services on August 1, 2021. R3's diagnosis included diabetes, gastroesophageal reflux disease (GERD), malignant neoplasm of the endometrium and spinal stenosis of lumbar. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R3. R3's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R3 received assistance with housekeeping, dressing assistance, laundry, medication setup, activity assistance, and vital signs. R4 R4 was admitted the licensee on March 19, 2017, and began receiving assisted living services on August 1, 2021. R4's diagnosis included schizo-affective disorder, chronic obstructive pulmonary disease, panic	0 900			

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0 900	Continued From page 46 disorder, and post-traumatic stress disorder. R4's undated and unsigned service plan indicated R4 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility, medication administration, behavior management, housekeeping and linen changes. R5 R5 was admitted to the licensee on September 1, 2020, and began receiving assisted living services on August 1, 2021. R5's diagnosis included schizo-affective disorder, anxiety, hyperlipidemia, and seizure disorder. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R5. R5's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R5 received assistance with dressing, behavior management, medication setup, laundry, housekeeping, vital signs, grooming assistance, and linen changes. R9 R9 was admitted to the licensee on August 28, 2023, to receive assisted living services. R9's diagnosis included schizophrenia and Parkinson's disease. R9's unsigned service plan dated January 4, 2024, indicated R9 received standby assistance with activities, setup assistance with bathing, setup assistance with dining, activity reminders, assistance with shopping, assistance with	0 900			

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0 900	Continued From page 47 transportation, assistance with TED hose, case management, bed making, housekeeping, personal laundry, medications setup, medication administration, behavior management, and safety checks. R2, R3, R4, R5, and R9's records all lacked documentation of a contract being executed prior to being provided assisted living services. No contracts were found in the resident records. On February 6, 2025, at 4:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated once the licensee takes on a new resident, they call the guardian to have a meeting to get all the forms signed. Additionally, LALD/CNS-B stated "I know we do have issues with this. I know we have a couple that have not signed. We keep them on file and inform the case manager when they come on site to get it signed. I know it's not right, but what can you do." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
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 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.	0 970			

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0 970	Continued From page 48 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated Assisted Living Contract which contained language under Miscellaneous Provisions 1. Insurance Liability and Release indicated the resident agreed that the licensee "will not be liable to the resident for any personal injury or property damage." The licensee's blank assisted living contract also indicated all residents would have a completed assisted living contract prior to admission. On February 6, 2025, at 3:57 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-B stated they were not aware the licensee's contract could not contain the information noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			

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01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for five of nine employees (administrator (A)-A, unlicensed personnel (ULP)-C, ULP-D, registered nurse (RN)-E, and licensed practical nurse (LPN)-H). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01290			

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NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016			
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01290	Continued From page 50 The findings include: On February 3, 2025, at 2:10 p.m., the surveyor observed A-A access the licensee's NETStudy 2.0 (web-based system for submitting background study requests to the Minnesota Department of Human Services (DHS)) website roster page and email the CSV formatted file with the licensee's background study roster to the surveyor. A-A The licensee's employee list form lacked documentation of a hire date for A-A. The licensee's NETSTudy 2.0 CVS file indicated A-A's background study was run through an affiliated but expired comprehensive homecare licensure HFID 25202, and indicated "Eligible - COVID-19 Study - Expired". During the survey process, on February 3, and 4, 2025, the surveyor observed A-A accessing resident and employee records for the surveyor. ULP-C ULP-C was hired February 14, 2024, to provide assisted living services. ULP-C's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license prior to the start of the survey. The licensee's NETSTudy 2.0 CVS file did not include ULP-C. On February 4, 2025, the surveyor observed ULP-C administer medications to residents residing within the facility in an unsupervised	01290			

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01290	Continued From page 51 capacity. ULP-D The licensee's employee roster form indicated ULP-D was hired September 2024 to provide assisted living services. ULP-D's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license prior to the start of the survey. The licensee's NETSTudy 2.0 CVS file did not include ULP-D. On February 4, 2025, the surveyor observed ULP-D providing assisted living services to residents residing within the facility in an unsupervised capacity. RN-E RN-E was hired on August 7, 2024, to provide clinical oversight and supervision of unlicensed personnel. The licensee's NETSTudy 2.0 CVS file indicated RN-E had a background study affiliated to the licensee's HFID 34363, dated April 1, 2024, which indicated "Disqualified - Not Set Aside". On February 4, 2025, at 11:58 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board	01290			

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01290	Continued From page 52 issues the following Order: 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." LPN-H The licensee's employee roster form indicated LPN-H was hired December 2023 to provide assisted living services. LPN-H's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license prior to the start of the survey. On February 4, 2025, the surveyor observed LPN-H accessing resident medical records and providing medication management services for residents residing within the facility in an unsupervised capacity. On February 4, 2025, at 1:21 p.m., A-A stated they were responsible for managing the licensee's background study rosters. A-A stated they believed their practice for running background checks was changed when the price had increased for running background studies. A-A stated the licensee had begun running all background checks in one big batch quarterly instead of at the time of hire. A-A stated they were under the assumption background studies needed to be run on an annual basis. A-A stated they were unaware that COVID background studies had expired. On February 4, 2025, Minnesota Department of Human Services website, "Background studies" indicated that DHS temporarily modified background studies during the COVID-19	01290			

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01290	Continued From page 53 pandemic. Those modifications ended January 1, 2023. On February 4, 2025, Minnesota Department of Human Services website, "Emergency background studies end" indicated that emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant fingerprint-based background study. The Licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the employment process included following: The criminal background check will be submitted to Minnesota Department of Humans Services (DHS) following the step-by-step procedure established by DHS. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01310 SS=I	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as staff members of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.	01310			

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01310	Continued From page 54 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure a registered nurse (RN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of two employees (RN-E), which had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 3, 2025, at 10:00 a.m., administrator (A)-A provided the licensee's employee list. The employee list indicated RN-E was working for the licensee as a RN. On February 3, 2025, at 2:10 p.m., the surveyor observed A-A access the licensee's NETStudy 2.0 (web-based system for submitting background study requests to the Minnesota Department of Human Services (DHS)) website roster page and email the CSV formatted file with the licensee's background study roster to the surveyor. On February 4, 2025, at 11:28 a.m., A-A stated RN-E's hire date was August 7, 2024. RN-E was	01310			

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01310	Continued From page 55 hired to provide clinical oversight and supervision of unlicensed personnel. On February 4, 2025, at 11:58 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board issues the following Order: 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." The licensee's NETSTudy 2.0 CVS file indicated RN-E had a background study affiliated to the licensee's HFID 34363, dated April 1, 2024, which indicated "Disqualified - Not Set Aside". On February 4, 2025, at 9:34 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were currently out of the country and RN-E was responsible for clinical oversight during their absence. On February 4, 2025, at 12:09 p.m., licensed practical nurse (LPN)-H stated they were not sure how long LALD/CNS-B has been out of country, but that RN-E was responsible for all clinical supervision in their stead. Additionally, LPN-H stated that RN-E was responsible for all assessments for residents residing within the facility. On February 4, 2025, at 1:12 p.m., RN-E stated	01310			

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01310	Continued From page 56 LALD/CNS-B had been out of the country since December 20, 2024, and during the absence of LALD/CNS-B, they had overseen all tasks of the clinical nurse supervisor. RN-E stated they were responsible for all assessments of residents and supervision of unlicensed personnel in addition to verifying and transcribing orders from resident's medical providers. RN-E stated they expected LALD/CNS-B to return from Nigeria by the end of the month. On February 4, 2025, at 1:28 p.m., A-A stated LALD/CNS-B had been responsible for verifying credentials upon hire, and they were not aware RN-E's nursing license had been revoked. The licensee's undated document titled Triple Angels Healthcare position description - Registered Nurse/RN Case Manager indicated applicants must be a graduate of accredited nursing program and licensed as a registered nurse in the State of Minnesota. DHS BACKGROUND STUDIES, DISQUALIFICATIONS, AND SET-ASIDES, dated February 2008 indicated the status of Not Set-Aside indicated the Commissioner determined that the applicant had failed to provide sufficient evidence that they no longer pose a risk of harm, the disqualification remains; the offense is not set aside. Minnesota State Statute 148.283 UNAUTHORIZED PRACTICE OF PROFESSIONAL, ADVANCED PRACTICE REGISTERED, AND PRACTICAL NURSING indicated, "The practice of advanced practice, professional, or practical nursing by any person who has not been licensed to practice advanced practice, professional, or practical nursing under	01310			

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01310	Continued From page 57 the provisions of sections 148.171 to 148.285, or whose license has been suspended or revoked, or whose registration or national credential has expired, is hereby declared to be inimical to the public health and welfare and to constitute a public nuisance..." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01310			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370			

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01370	Continued From page 58 licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel (unlicensed personnel (ULP)-C, ULP-F). 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 February 5, 2025, at 1:07 p.m., administrator (A)-A provided a printed transcript of ULP-C and ULP-F's training record, and verified the documents reflected all of ULP-C's and ULP-F's training.	01370			

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01370	Continued From page 59 ULP-C ULP-C was hired February 24, 2024, to provide assisted living services. On February 4, 2025, the surveyor observed ULP-C administer medications to residents residing within the facility in an unsupervised capacity. ULP-C's record lacked documentation of training and competency evaluations in the following areas: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; and - understanding appropriate boundaries between staff and residents and the resident's family. ULP-F ULP-F was hired August 28, 2023, to provide assisted living services. On February 5, 2025, at 4:44 p.m. the surveyor observed ULP-F provide assisted living services to residents residing within the facility.	01370			

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01370	Continued From page 60 R9's medication administration record (MAR) dated January 1, 2025, to February 5, 2025, indicated on January 7, 2025, ULP-F documented administration of medications for R9. ULP-F's record lacked documentation of training and competency evaluations in the following areas: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - care and use of hearing aids; - training on the prevention of falls; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On February 6, 2025, at 3:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated that they, and A-A were responsible for ensuring staff were oriented and trained in on all required content. LALD/CNS-B stated they were not aware staff had not recieved all required trainings.	01370			

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01370	Continued From page 61 The licensee's Staff Competency policy dated July 13, 2015, indicated the following: "Training and competency evaluations for all unlicensed personnel (basic and comprehensive) include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for Triple Angels Healthcare until they have successfully passed the written (at 80%) and demonstration competency evaluation. a. Documentation requirements for all services provided b. Reports of changes in the resident's condition to the supervisor designated by the home care provider c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. f. Training on the prevention of falls for providers working with the elderly or those at risk of falls g. Standby assistance techniques and how to perform them h. Medication, exercise and treatment reminders i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating j. Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the resident's family m. Procedures to utilize in handling various	01370			

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01370	Continued From page 62 emergency situations n. Awareness of commonly used health technology equipment and assistive devices" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel (unlicensed personnel (ULP)-C, ULP-F).	01380			

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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
01380	Continued From page 63 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 February 5, 2025, at 1:07 p.m., administrator (A)-A provided a printed transcript of ULP-C and ULP-F's training record, and verified the documents reflected all of ULP-C's and ULP-F's training. ULP-C ULP-C was hired February 24, 2024, to provide assisted living services. On February 4, 2025, the surveyor observed ULP-C administer medications to residents residing within the facility in an unsupervised capacity. ULP-C's record lacked documentation of training and competency evaluations in the following areas: - observation, reporting, and documenting of resident status; and - safe transfer techniques and ambulation. ULP-F ULP-F was hired August 28, 2023, to provide assisted living services. On February 5, 2025, at 4:44 p.m. the surveyor observed ULP-F provide assisted living services	01380			

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01380	Continued From page 64 to residents residing within the facility. R9's medication administration record (MAR) dated January 1, 2025, to February 5, 2025, indicated on January 7, 2025, ULP-F documented administration of medications for R9. ULP-F's record lacked documentation of training and competency evaluations in the following areas: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - administering medications or treatments as required. On February 6, 2025, at 3:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated that they, and A-A were responsible for ensuring staff were oriented and trained in on all required content. LALD/CNS-B stated they were not aware staff had not recieved all required trainings. The licensee's Staff Competency policy dated July 13, 2015, indicated the following: " Home Health Aides may not work for Triple Angels Healthcare until they have successfully passed the written and demonstration competency evaluation. i. Satisfactory completion of the following ii. Observation, reporting and documenting of resident status	01380			

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01380	Continued From page 65 iii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iv. Recognizing physical, emotional, cognitive and development needs of the resident v. Basic infection control, including blood-borne pathogens vi. Maintenance of a clean and safe environment vii. Falls prevention viii. Safe transfer techniques and ambulation ix. Range of motion and positioning x. Medication, exercise and treatment reminders xi. Basic nutrition, meal preparation, food safety and assistance with eating xii. Preparation of modified diets xiii. Communication skills and barriers xiv. Cultural diversity xv. Confidentiality/privacy xvi. Professional boundaries xvii. Handling of emergencies xviii. Commonly used health technology equipment and assistive devices " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not	01460			

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01460	Continued From page 66 transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for two of two employees (unlicensed personnel (ULP)-C, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01460			

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01460	Continued From page 67 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 February 3, 2025, at approximately 10:30 a.m., administrator (A)-A stated they were aware of the required content for employee records. ULP-C ULP-C was hired February 24, 2024, to provide assisted living services. On February 4, 2025, the surveyor observed ULP-C providing medication administration to residents residing within the facility. ULP-C's record lacked the following required orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults or minors; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery. ULP-F ULP-F was hired August 28, 2023, to provide assisted living services.	01460			

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01460	Continued From page 68 On February 5, 2025, at 4:44 p.m. the surveyor observed ULP-F provide assisted living services to residents residing within the facility. ULP-F's record lacked the following required orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery. On February 5, 2025, at 1:07 p.m., administrator (A)-A provided a printed transcript of ULP-C and ULP-F's training record, and verified the documents reflected all of ULP-C's and ULP-F's training. On February 6, 2025, at 3:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated that they, and A-A were responsible for ensuring staff were trained and oriented on all required content. LALD/CNS-B stated they were not aware staff had not recieved all required trainings. The licensee's Staff Orientation and Education policy dated July 13, 2015, indicated those providing direct services will complete a competency evaluation as part of the orientation	01460			

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01460	Continued From page 69 process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
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: Based on observation, interview, and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 80 hours of the employment start date for one of one employee (unlicensed personnel (ULP)-C) with record reviewed. This practice resulted in a level two violation (a	01540			

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01540	Continued From page 70 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: ULP-C was hired February 14, 2025, to provide assisted living services. On February 4, 2025, from 7:35 a.m., to 9:27 a.m., the surveyor observed ULP-C provide assisted living services to residents residing within the facility. On February 4, 2025, at 7:48 a.m., ULP-C stated they recalled receiving dementia training upon hire. ULP-C stated they believed the training module they received took less than one hour to complete. On February 6, 2025, at 3:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were responsible for ensuring staff receive required training. Additionally, LALD/CNS-B stated they believed staff were required to receive around three hours of dementia training at time of hire. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must complete at least eight (8) hours of initial education within 160 working hours of the employment start date. No further information was provided.	01540			

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01540	Continued From page 71	01540			
01610 SS=D	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of eight residents (R2) on or before the admission date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01610			

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01610	Continued From page 72 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: R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R2's record contained an admission assessment with date of March 1, 2023. This indicated 29 days had lapsed since R2's admission and R2's admission assessment. The admission assessment was signed as being completed by registered nurse (RN)-E. RN-E was not available for interview. On February 6, 2025, at 4:07 p.m., licensed	01610			

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01610	Continued From page 73 assisted living director/clinical nurse supervisor (LALD/CNS)-B stated, "we do assessments upon admission, 14 days, 30 days, and then annually, or with change of condition." The licensee's Assessment and Reassessment dated August 1, 2021, indicated the initial RN assessment shall be complete prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620			

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01620	Continued From page 74 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for all residents residing within the facility as required. 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: RN-E was hired on August 7, 2024, to provide clinical oversight and supervision of unlicensed personnel. On February 4, 2025, at 11:58 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board issues the following Order:	01620			

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01620	Continued From page 75 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R2's record contained a 90-day assessment completed by RN-E, dated September 25, 2024. The assessment was the most recent assessment completed by a licensed registered nurse, which indicated on February 6, 2025, 134 days had lapsed since the last assessment. R2's record contained an additional assessment dated December 27, 2024, which was completed by RN-E, however, was completed past the date of RN-E's license revocation, therefore invalidating	01620			

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01620	Continued From page 76 the assessment. R3 R3 was admitted to the licensee on June 14, 2019, and began receiving assisted living services on August 1, 2021. R3's diagnosis included diabetes, gastroesophageal reflux disease (GERD), malignant neoplasm of the endometrium and spinal stenosis of lumbar. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R3. R3's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R3 received assistance with housekeeping, dressing assistance, laundry, medication setup, activity assistance and vital signs. R3's record contained a clinical update assessment completed by RN-E, dated September 7, 2024. The assessment was the most recent assessment completed by a licensed registered nurse, which indicated on February 6, 2025, 152 days had lapsed since the last assessment. R3's record contained an additional clinical update assessment dated December 6, 2024, which was completed by RN-E, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. R4 R4 was admitted the licensee on March 19, 2017, and began receiving assisted living services on August 1, 2021.	01620			

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01620	Continued From page 77 R4's diagnosis included schizo-affective disorder, chronic obstructive pulmonary disease, panic disorder, and post-traumatic stress disorder. R4's undated and unsigned service plan indicated R4 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility, medication administration, behavior management, housekeeping and linen changes. R4's record contained a clinical update assessment completed by RN-E, dated September 6, 2024. The assessment was the most recent assessment completed by a licensed registered nurse, which indicated on February 6, 2025, 153 days had lapsed since the last assessment. R4's record contained an additional clinical update assessment dated November 27, 2024, which was completed by RN-E, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. R5 R5 was admitted to the licensee on September 1, 2020, and began receiving assisted living services on August 1, 2021. R5's diagnosis included schizo-affective disorder, anxiety, hyperlipidemia, and seizure disorder. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R5. R5's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R5 received assistance with dressing, behavior management, medication setup, laundry, housekeeping, vital signs,	01620			

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NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016		
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01620	Continued From page 78 grooming assistance, and linen changes. R5's record contained a clinical update assessment completed by RN-E, dated September 6, 2024. The assessment was the most recent assessment completed by a licensed registered nurse, which indicated on February 6, 2025, 153 days had lapsed since the last assessment. R5's record contained an additional 90-day assessment dated November 29, 2024, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. R6 R6 was admitted to the licensee on May 17, 2016, and began receiving assisted living services on August 1, 2021. R6's diagnosis included encephalopathy, Wernicke's, caner of the endometrium, adenocarcinoma stage 1 and muscle weakness. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R6. R6's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R6 received assistance with dressing, medication setup, laundry, housekeeping, vital signs, grooming assistance, incontinence care and linen changes. R6's record contained a clinical update assessment completed by RN-E, dated September 6, 2024. The assessment was the most recent assessment completed by a licensed registered nurse, which indicated on February 6, 2025, 153 days had lapsed since the last	01620			

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01620	Continued From page 79 assessment. R6's record contained an additional clinical update assessment dated November 15, 2024, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. R7 R7 was admitted to the licensee on May 13, 2024, and began receiving assisted living services on August 1, 2021. R7's diagnosis included head injury, vascular dementia, and depression. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R7. R7's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R7 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, bathing assistance, and laundry. R7's record contained a 90-day assessment completed by RN-E, dated September 11, 2024. The assessment was the most recent assessment completed by a licensed registered nurse which indicated on February 6, 2025, 148 days had lapsed since the last assessment. R7's record contained an additional clinical update assessment dated November 27, 2024, and a 90-day assessment dated December 11, 2024, however, were completed past the date of RN-E's license revocation, therefore invalidating the assessment. R8 R8 was admitted to the licensee on January 29,	01620			

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01620	Continued From page 80 2020, and began receiving assisted living services on August 1, 2021. R8's diagnosis included Huntington's disease and history of alcohol abuse. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R8. R8's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R8 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, assistance with drinking, skin care, vital signs, linen changes, escort and mobility assistance, transfer assistance and supervision of special diets. R8's record contained a 90-day assessment completed by RN-E, dated September 6, 2024. The assessment was the most recent assessment completed by a licensed registered nurse which indicated on February 6, 2025, 153 days had lapsed since the last assessment. R8's record contained an additional clinical update assessment dated November 17, 2024, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. R9 R9 was admitted to the licensee on August 28, 2023, to receive assisted living services. R9's diagnosis included schizophrenia and Parkinson's disease. R9's unsigned service plan dated January 4, 2024, indicated R9 received standby assistance with activities, setup assistance with bathing,	01620			

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01620	Continued From page 81 setup assistance with dining, activity reminders, assistance with shopping, assistance with transportation, assistance with TED hose, case management, bed making, housekeeping, personal laundry, medications setup, medication administration, behavior management, and safety checks. R9's record contained a clinical update assessment completed by RN-E, dated October 4, 2024. The assessment was the most recent assessment completed by a licensed registered nurse which indicated on February 6, 2025, 125 days had lapsed since the last assessment. R9's record contained an additional 90-day assessment dated January 3, 2024, however, was completed past the date of RN-E's license revocation, therefore invalidating the assessment. On February 4, 2025, at 1:28 p.m., administrator (A)-A stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B had been responsible for verifying credentials upon hire, and they were not aware RN-E's nursing license had been revoked. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 82 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care 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 observation, interview, and record review, the licensee failed to ensure each resident had a current service plan with a signature or other authentication by the resident to document agreement on the services to be provided for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01640			

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01640	Continued From page 83 a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R3 R3 was admitted to the licensee on June 14, 2019, and began receiving assisted living services on August 1, 2021. R3's diagnosis included diabetes, gastroesophageal reflux disease (GERD), malignant neoplasm of the endometrium and spinal stenosis of lumbar. Although requested, the licensee failed to provide	01640			

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01640	Continued From page 84 documentation of a signed or unsigned service plan for R3. R3's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R3 received assistance with housekeeping, dressing assistance, laundry, medication setup, activity assistance, and vital signs. R4 R4 was admitted the licensee on March 19, 2017, and began receiving assisted living services on August 1, 2021. R4's diagnosis included schizo-affective disorder, chronic obstructive pulmonary disease, panic disorder, and post-traumatic stress disorder. R4's record contained an undated and unsigned service plan which indicated R4 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility, medication administration, behavior management, housekeeping and linen changes. R5 R5 was admitted to the licensee on September 1, 2020, and began receiving assisted living services on August 1, 2021. R5's diagnosis included schizo-affective disorder, anxiety, hyperlipidemia, and seizure disorder. The licensee failed to provide documentation of a signed or unsigned service plan for R5. R5's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R5 received assistance with	01640			

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01640	Continued From page 85 dressing, behavior management, medication setup, laundry, housekeeping, vital signs, grooming assistance, and linen changes. R6 R6 was admitted to the licensee on May 17, 2016, and began receiving assisted living services on August 1, 2021. R6's diagnosis included encephalopathy, Wernicke's, caner of the endometrium, adenocarcinoma stage 1, and muscle weakness. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R6. R6's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R6 received assistance with dressing, medication setup, laundry, housekeeping, vital signs, grooming assistance, incontinence care, and linen changes. R7 R7 was admitted to the licensee on May 13, 2024, and began receiving assisted living services on August 1, 2021. R7's diagnosis included head injury, vascular dementia, and depression. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R7. R7's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R7 received assistance with grooming, dressing, incontinence care, behavior	01640			

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01640	Continued From page 86 management, medication setup, bathing assistance, and laundry. R8 R8 was admitted to the licensee on January 29, 2020, and began receiving assisted living services on August 1, 2021. R8's diagnosis included Huntington's disease and history of alcohol abuse. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R8. R8's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R8 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, assistance with drinking, skin care, vital signs, linen changes, escort and mobility assistance, transfer assistance, and supervision of special diets. R9 R9 was admitted to the licensee on August 28, 2023, to receive assisted living services. R9's diagnosis included schizophrenia and Parkinson's disease. R9's record contained an unsigned service plan dated January 4, 2024, which indicated R9 received standby assistance with activities, setup assistance with bathing, setup assistance with dining, activity reminders, assistance with shopping, assistance with transportation, assistance with TED hose, case management, bed making, housekeeping, personal laundry, medications setup, medication administration,	01640			

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01640	Continued From page 87 behavior management, and safety checks. On February 6, 2025, at 4:07 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated most of the resident's families were not involved, so the licensee leaves the service plans for the case managers to get a signature from the family. Licensee's Service Plan Policy, dated August 1, 2021, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. Additionally, initial and any revisions are signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750			

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01750	Continued From page 88 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the unlicensed personnel (ULP) were able to demonstrate the ability to competently follow the procedure for one of three employees (ULP-F). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired August 28, 2023, to provide assisted living services. ULP-F's record contained competency training dated October 24, 2024. ULP-F's record lacked documentation of competency for medication administration training provided by the registered nurse. On February 5, 2025, at 2:25 p.m., ULP-F stated they received medication administration training from RN-E. ULP-F stated they believed the competency training for medication administration	01750			

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01750	Continued From page 89 occurred on the same date as the other listed trainings. R9's medication administration record (MAR) dated January 1, 2025, to February 5, 2025, indicated on January 7, 2025, ULP-F documented administration of medications for R9. RN-E RN-E was hired on August 7, 2024, to provide clinical oversight and supervision of unlicensed personnel. A letter of notification addressed to the licensee, health facility identification number (HFID) 34363, Re: RN-E, dated May 18, 2024, from the Department of Human Services indicated the following: "You are hereby ordered to remove the above-named individual from any position allowing direct contact with, or access to, people served by your program." On February 4, 2025, at 11:58 p.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board issues the following Order: 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." The licensee's Delegation of Assisted Living	01750			

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01750	Continued From page 90 Tasks policy dated August 1, 2021, indicated the registered nurse is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of tasks in accordance with the appropriate Minnesota Practice Act. The licensee knowingly utilized an employee they had been ordered by DHS to remove, to train individuals who administered medications and provided other direct cares. The employee had their RN license revoked, thereby rendering the RN required trainings invalid. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to store all prescription medications securely to permit only authorized personnel to have access. 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	01880			

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01880	Continued From page 91 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 February 4, 2025, during continuous observation from 7:48 a.m., to 9:05 a.m., the surveyor observed ULP-C prepare and administer medications for all residents within the facility. ULP-C was observed setting up morning medications within a lockable medication room set inside of a lockable nursing station. At 8:09 a.m., after setting up medications, ULP-C was observed leaving the lockable medication room and lockable nursing station open and unattended to administer medications to R4. At 8:10 a.m., ULP-C returned to the medication room to remove gloves and complete hand hygiene before obtaining additional medications and leaving room unattended again to administer medications. At 8:13 a.m., ULP-C returned to the unsecured medication room to complete hand hygiene and document administration. At 8:33 a.m., after setting up medications, ULP-C was observed leaving the lockable medication room and lockable nursing station open and unattended to administer medications to R5. At 8:34 a.m., ULP-C returned to the medication room to remove gloves and complete hand hygiene and document administration. At 8:54 a.m., after setting up medications, ULP-C was observed leaving the lockable medication room and lockable nursing station open and unattended to administer medications to R2. At 8:56 a.m., ULP-C returned to the medication room to remove gloves and complete hand hygiene and document administration. At 9:04 a.m., after setting up medications, ULP-C was observed leaving the lockable medication room	01880			

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NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016		
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01880	Continued From page 92 and lockable nursing station open and unattended to administer medications to R5. At 9:05 a.m., ULP-C returned to the medication room to remove gloves and complete hand hygiene and document administration. On February 4, 2025, at 9:16 a.m., ULP-C stated they were trained to secure the medication room between all medication passes. On February 6, 2025, at 4:01 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated staff were trained and were expected to secure the medication room in between all medication passes. During the survey process, the surveyor was unable to obtain a specific policy on the secure storage of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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	02040			

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02040	Continued From page 93 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment 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 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 February 4, 2025, at 12:30 p.m., a record review and interview were conducted with administrator (A)-A on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. On February 4, 2025, at 1:00 p.m., A-A stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			

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02310	Continued From page 94	02310			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents (R2, R7, R8) who utilized bed rails when they failed to ensure a licensed registered nurse conducted timely bed rail assessments and failed to ensure bed rail assessments contained all necessary information to mitigate the safety risks. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-E was hired on August 7, 2024, to provide clinical oversight and supervision of unlicensed personnel. On February 4, 2025, at 11:58 p.m., the surveyor	02310			

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02310	Continued From page 95 observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated RN-E had a public action attached to their record. The attached document titled Findings of Fact, Conclusions, and Final Order dated October 11, 2024, indicated the following: "Based on the foregoing Findings of Fact and Conclusions and upon the recommendation of the ALJ (Administrative Law Judge), the Board issues the following Order: 1. IT IS HEREBY ORDERED that Licensee's license as a professional nurse in the State of Minnesota is REVOKED immediately for a minimum of 10 years." These findings invalidated any assessments completed by RN-E taking place after the date of October 11, 2024. R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. On February 3, 2025, at 11:06 a.m., during a tour of the facility, the surveyor observed a hospital style bed with two upper bed rails with the right side in the low position and the left side in the raised position in the room of R2. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R2.	02310			

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02310	Continued From page 96 R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R2's record contained assessments completed by RN-E, dated September 25, 2024, and December 27, 2024, which included a bed rail assessment section. The bed rail assessments lacked inclusion of measurements of the hospital bed rail entrapment zones. The December 27, 2024, assessment was conducted past the date of RN-E's license revocation, therefore invalidating the assessment. This indicated as of February 6, 2025, 134 days had lapsed since the last bed rail assessment was completed by a licensed registered nurse. R7 R7 was admitted to the licensee on May 13, 2024, and began receiving assisted living services on August 1, 2021. On February 3, 2025, at 11:06 a.m., during a tour of the facility, the surveyor observed a hospital style bed with a bed rail in the low position in the room of R7. R7's diagnosis included head injury, vascular dementia, and depression. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R7. R7's record contained a document with a print	02310			

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02310	Continued From page 97 date of February 6, 2025, titled Schedule of Care which indicated R7 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, bathing assistance, and laundry. R7's record contained assessments completed by RN-E, dated September 11, 2024, November 27, 2024, and December 11, 2024, which included a bed rail assessment section. The bed rail assessments lacked inclusion of measurements of the hospital bed rail entrapment zones. The November 27, 2024, and December 11, 2024, assessments were conducted past the date of RN-E's license revocation, therefore invalidating the assessments. This indicated as of February 6, 2025, 148 days had lapsed since the last bed rail assessment was completed by a licensed registered nurse. R8 R8 was admitted to the licensee on January 29, 2020, and began receiving assisted living services on August 1, 2021. R8's diagnosis included Huntington's disease and history of alcohol abuse. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R8. R8's record contained a document titled Schedule of Care which indicated R8 received assistance with grooming, dressing, incontinence care, behavior management, medication setup, assistance with drinking, skin care, vital signs, linen changes, escort and mobility assistance, transfer assistance and supervision of special diets.	02310			

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02310	Continued From page 98 R8's record contained assessments completed by RN-E, dated September 6, 2024, and November 17, 2024, which included a bed rail assessment section. The assessents lacked the following required components of a bedrail assessent: - purpose and intention of the bed rail; - the residnets bed rail use/need assessment; - the residents preference; - Risk vs. benefits discussion; - documentation of the installation and use according to manufacturer guidelines. The November 17, 2024, assessment was conducted past the date of RN-E's license revocation, therefore invalidating the assessment. This indicated as of February 6, 2025, 153 days had lapsed since the last bed rail assessment was completed by a licensed registered nurse. On February 4, 2025, at 1:28 p.m., administrator (A)-A stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B had been responsible for verifying credentials upon hire, and they were not aware RN-E's nursing license had been revoked. On February 6, 2025, 4:09 p.m., LALD/CNS-B stated the licensee had a form that was used for bed rail assessments. LALD/CNS-B stated the licensee would send the form to the resident's doctor to get approval of the bed rail. After that, their practice was to assess the bed rails annually or with any change in condition. The licensee's policy titled Side Rail Use dated August 1, 2021, indicated the need for siderails will be reassessed and documented as needed, but not less than every 90 days. No further information was provided.	02310			

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02310	Continued From page 99	02310			
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents had the right to come and go from the facility as they choose. This affected four of eight residents (R2, R3, R4, R9) whom the licensee had admitted to their secured dementia care unit without a dementia related diagnosis and/or for reasons not related to their diagnoses. 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 an Assisted Living with Dementia Care license issued on November 1, 2024, with an expiration date of October 31, 2025. On February 3, 2025, at 11:05 a.m., the surveyor toured the facility with administrator (A)-A. The	02370			

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02370	Continued From page 100 facility consisted of 10 bedrooms set up for double occupancy. The entire facility was secured via locked doors, and the front entryway was secured via keypad. On February 3, 2025, at 12:52 p.m., administrator (A)-A stated that residents residing within the facility were able to come and go as needed. On February 4, 2025, 7:53 a.m., unlicensed personnel (ULP)-C stated according to their training, no residents were allowed to leave the facility without direct supervision by staff. R2 R2 was admitted to the licensee on January 31, 2023, to receive assisted living services. R2's diagnosis included failure to thrive, leg pain and swelling, borderline personality disorder, parkinsonian tremor, chronic pain, microcystic anemia, post-traumatic stress disorder, depressive disorder, bulimia nervosa, bipolar disorder, obesity, tobacco abuse, B12 deficiency, and hypokalemia. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R2. R2's record contained a document with a print date of February 6, 2025, titled Schedule of Care, which indicated R2 received assistance with positioning, grooming, toileting, assistance with transfers, incontinence care, behavior management, housekeeping, linen change, bathing assistance, medication setup, and assistance with dressing. R2's record contained a 90-day assessment	02370			

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02370	Continued From page 101 dated September 25, 2024. The assessment was the most recent assessment completed by a licensed registered nurse. The September 25, 2024, assessment indicated R2 was their own decision maker, was oriented to person, place, and time, and had not wandered. R2's Master Care Plan last updated December 27, 2024, indicated R2 was not at risk for elopement, and was able verbalize their needs, was oriented to person, place, and time, and had not wandered. R2's Individual Abuse Prevention Plan as of February 5, 2025, indicated R2 as not at risk for elopement or wandering. R3 R3 was admitted to the licensee on June 14, 2019, and began receiving assisted living services on August 1, 2021. R3's diagnosis included diabetes, gastroesophageal reflux disease (GERD), malignant neoplasm of the endometrium, and spinal stenosis of lumbar. Although requested, the licensee failed to provide documentation of a signed or unsigned service plan for R3. R3's record contained a document with a print date of February 6, 2025, titled Schedule of Care which indicated R3 received assistance with housekeeping, dressing assistance, laundry, medication setup, activity assistance, and vital signs. R3's record contained a 90-day assessment dated September 7, 2024. The assessment was	02370			

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02370	Continued From page 102 the most recent assessment completed by a licensed registered nurse. The September 7, 2024, assessment indicated R3 was their own decision maker, was oriented to person, place, and time, and had not wandered. R3's Master Care Plan last updated December 6, 2024, indicated R3 was not at risk for elopement, and was able verbalize their needs, was oriented to person, place, and time, and had not wandered. R3's Individual Abuse Prevention Plan as of December 6, 2024, indicated R3 was not at risk for elopement or wandering. On February 5, 2025, at 11:08 a.m., R3 stated they did not have the access codes to get in and out of the facility. R4 R4 was admitted the licensee on March 19, 2017, and began receiving assisted living services on August 1, 2021. R4's diagnosis included schizo-affective disorder, chronic obstructive pulmonary disease, panic disorder, and post-traumatic stress disorder. R4's record contained an undated and unsigned service plan which indicated R4 received assistance with dressing, assistance with grooming, assistance with toileting, assistance with mobility, medication administration, behavior management, housekeeping, and linen changes. R4's record contained a 90-day assessment dated September 6, 2024. The assessment was the most recent assessment completed by a licensed registered nurse. The September 6,	02370			

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02370	Continued From page 103 2024, assessment indicated R4 was their own decision maker, was oriented to person, place, and time, but was confused at times and had not wandered. R4's Master Care Plan last updated November 27, 2024, indicated R4 was alert and oriented, had behavioral issues but was not at risk of elopement. R4's Individual Abuse Prevention Plan as of November 27, 2024, indicated R4 as not at risk for elopement or wandering. On February 5, 2025, at 10:54 a.m., R4 stated any time they wanted to leave the facility, they had to be accompanied by staff. R9 R9 was admitted to the licensee on August 28, 2023, to receive assisted living services. R9's diagnosis included schizophrenia and Parkinson's disease. R9's record contained an unsigned service plan dated January 4, 2024, which indicated R9 received standby assistance with activities, setup assistance with bathing, setup assistance with dining, activity reminders, assistance with shopping, assistance with transportation, assistance with TED hose, case management, bed making, housekeeping, personal laundry, medications setup, medication administration, behavior management, and safety checks. R9's record contained a 90-day assessment dated October 4, 2024, which indicated R9 was not at risk of wandering and was oriented to person, place and time. The portion of the	02370			

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02370	Continued From page 104 assessment titled "Safety", under the section title "Risk of Elopement/Wandering" indicated "Resident is not at risk of elopement/wandering: yes", which appeared to indicate that R9 was not at risk for elopement. Additionally, the assessment indicated that in the event of an evacuation, R9 was self-sufficient, ambulatory, required minimal nursing care, and required no or minimal assistance in the event of an evacuation. R9's Master Care Plan last updated January 3, 2025, indicated R9 was not at risk for elopement, was able verbalize their needs, was oriented to person, place, and time. R9's Individual Abuse Prevention Plan as of January 3, 2025, indicated R9 was not at risk for elopement or wandering. On February 5, 2025, social worker (SW)-J stated R9 was required to reside within a locked facility due to a mentally ill and dangerous (MI&D) commitment with the state. On February 5, 2025, at 1:38 p.m., during a phone conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated five of the eight residents did not have a dementia related diagnosis that required a secured unit, and they were aware that at least one of the eight residents residing within the facility were admitted under a MI&D order. 144G.08 subd. 8., Assisted living facility with dementia care, indicated "Assisted living facility with dementia care" means a licensed assisted living facility that is advertised, marketed, or otherwise promoted as providing specialized care for individuals with Alzheimer's disease or other dementias.	02370			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34363	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER TRIPLE ANGELS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016			
(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
02370	Continued From page 105 144G.08 subd. 16., Dementia, defines dementia as the loss of cognitive function, including the ability to think, remember, problem solve, or reason, of sufficient severity to interfere with an individual's daily functioning. Dementia is caused by different diseases and conditions, including but not limited to Alzheimer's disease, vascular dementia, neurodegenerative conditions, Creutzfeldt-Jakob disease, and Huntington's disease. 144G.08 subd. 17., Dementia care services, defines dementia care services as the ongoing care for behavioral and psychological symptoms of dementia, including planned group and individual programming and person-centered care practices provided according to section 144G.84 to support activities of daily living for people living with dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02370			

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Location:

Triple Angels Healthcare
7150 West Point Douglas Road S
Cottage Grove, MN55016
Washington County, 82

Establishment Info:

ID #: 0038521
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514589401
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1)

**** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND STORED OVER READY-TO-EAT ITEMS IN THE 2-DOOR STANDING COOLER. DISCUSSED REQUIRED STORAGE ORDER WITH STAFF ON SITE AND STAFF MOVED EGGS TO THE BOTTOM SHELF. CORRECTED ON SITE.

Comply By: 02/03/25

4-500 Equipment Maintenance and Operation

4-501.114C1

**** Priority 1 ****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

CHLORINE CONCENTRATION AT THE 3-COMPARTMENT SINK MEASURED AT 0PPM. DISCUSSED MIXING TECHNIQUE AND AMOUNT OF BLEACH PER WATER NEEDED FOR REQUIRED CONCENTRATIONS. MORE CHLORINE BLEACH ADDED DURING INSPECTION. CORRECTED ON SITE.

Comply By: 02/03/25

7-100 Toxic Labeling

7-102.11

**** Priority 2 ****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

(ORIGINALLY ISSUED 8/30/22): SPRAY BOTTLE CONTAINING DISH SOAP AND WATER FOUND UNLABELED. ENSURE ALL SPRAY BOTTLES ARE CLEARLY LABELED WITH THE COMMON

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NAME OF THEIR CONTENTS. REISSUED 2/3/25: CORRECTED ON SITE.

Comply By: 08/30/22

Surface and Equipment Sanitizers

Chlorine: = 0PPM at Degrees Fahrenheit
Location: 3-COMPARTMENT SINK
Violation Issued: No

Rinse Temp. Gauge: = at 185 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

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

Chlorine: = 100PPM at Degrees Fahrenheit
Location: 3-COMPARTMENT SINK *CORRECTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: 2-DOOR STANDING COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 40 Degrees Fahrenheit - Location: 2-DOOR STANDING COOLER
Violation Issued: No

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

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

- DISCUSSED:
- EMPLOYEE ILLNESS POLICY AND LOG
 - HANDWASHING
 - SANITIZER USE AND TEST KITS
 - 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
 - FOOD SERVICE PROCEDURES
 - PEST CONTROL
 - PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH CHRISTIAN, OTHER STAFF ON SITE, AND WITH THE NURSE EVALUATOR, ZACH.

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*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.

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 1004251026 of 02/03/25.

Certified Food Protection Manager: ADENIKE OGUNRINDE

Certification Number: FM101428 Expires: 11/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

ADENIKE OGUNRINDE
DIRECTOR

Signed: Molly Dougherty

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