DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 21, 2022

Administrator
VP At Goldfinch Estates LLC
850 Goldfinch Street
Fairmont, MN 56031

RE: Project Number(s) SL30399015

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 21, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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Electronically delivered

February 2, 2022

Administrator
VP At Goldfinch Estates LLC
850 Goldfinch Street
Fairmont, MN 56031

RE: Project Number(s) SL30399015

Dear Administrator:

On January 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 21, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 21, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 21, 2021, found not corrected at the time of the January 12, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 12, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 12, 2022, we identified the following violation(s):

1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30399	A. BUILDING: _____ B. WING _____	R 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VP AT GOLDFINCH ESTATES LLC	850 GOLDFINCH STREET FAIRMONT, MN 56031

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30399015-1 On January 10, 2022, through January 12, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 21, 2021. At the time of the survey, there were 113 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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	{0 680}		

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{0 680}	Continued From page 2 (5) have a written policy and procedure regarding missing tenant 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 complete a facility risk assessment and failed to have a comprehensive program for emergency preparedness that included all required components. 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 January 12, 2022, at approximately 1:05 p.m. interim licensed assisted living director (ILALD)-O stated he was working on the emergency preparedness policies and procedures but they were not all completed yet. Some of the policies	{0 680}		

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{0 680}	Continued From page 3 had been completed but had not been implemented yet. The licensee's plan lacked the following required content: - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - subsistence needs for staff and residents during emergency situation; - procedure for tracking staff and residents; - development of all policies/procedures, based on assessment; and additional policies for: - sheltering in place; - handling and use of volunteers; - development of a communication plan, including primary and alternate means for communication; and - methods for sharing information/family notifications. No additional information was provided.	{0 680}		
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		

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{0 810}	Continued From page 4	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	{01470}		

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{01470}	Continued From page 6 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-K and licensed practical nurse (LPN)-J received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-K and LPN-J training records lacked	{01470}		

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{01470}	Continued From page 7 evidence to indicate the employees had received orientation to include the following topics: - an overview of Chapter 144G; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-K and LPN-J began providing assisted living with dementia care services for the licensee on August 1, 2021. The employees' records lacked the above required content. On January 12, 2022, at 10:45 a.m. registered nurse (RN)-C confirmed ULP-K and LPN-J had not completed the required orientation. She thought the orientation to the new statutes had to be done by the ULP and was unaware all staff needed to complete it. Therefore, only ULP who attended the skills fair had completed the 144G updated orientation.	{01470}		

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{01470}	Continued From page 8 On January 12, 2022, at 11:17 a.m. RN-N, stated there were a total of nine ULP who had not completed the skills fair, thus had not completed the 144G required orientation for assisted living with dementia care. In addition, all other staff that were not ULP had not completed the training. No further information was provided.	{01470}		
{01620} SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	{01620}		

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{01620}	Continued From page 9 by: Based on interview and record review, the licensee failed to complete a 14-day assessment on one of one resident(R34) reviewed. In addition, the licensee failed to complete 90 day assessments for seven of thirteen residents (R34, R29, R30, R26, R31, R32, R33) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R34 R34 had an admission date of October 6, 2021. R34's diagnoses included, but were not limited to, hypertension (high blood pressure), and gastroesophageal reflux disease (heartburn). R34's last VPC Assessment (identified as a comprehensive assessment) was dated September 29, 2021, and was categorized as an admission/pre-move in assessment. R34's record lacked evidence a 14 day or subsequent 90-day assessment had been completed since September 29, 2021. R29 R29's diagnosis included macular degeneration (a vision impairment).	{01620}		

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{01620}	Continued From page 10 R29's last VPC Assessment was dated May 24, 2021, and was categorized as a 90 day assessment. R29's record lacked evidence an assessment had been completed since May 24, 2021. R30 R30's diagnoses included but were not limited to diabetes mellitus and hypertension (high blood pressure). R30's last VPC Assessment was dated May 30, 2021, and was categorized as a 90 day assessment. R30's record lacked evidence an assessment had been completed since May 30, 2021. R26 R26's record did not identify any diagnoses. R26's last VPC Assessment was dated August 9, 2021, and was categorized as a 90 day assessment. R26's record lacked evidence an assessment had been completed since August 9, 2021. R31 R31's record did not identify any diagnoses. R31's last VPC Assessment was dated September 9, 2021, and was categorized as a 90 day assessment. R31's record lacked evidence an assessment had been completed since September 9, 2021. R32 R32's diagnosis included chronic obstructive pulmonary disease (lung disease). R32's last VPC Assessment was dated	{01620}		

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{01620}	Continued From page 11 September 29, 2021, and was categorized as a change in condition assessment. R32's record lacked evidence an assessment had been completed since September 29, 2021. R33 R33's record did not identify any diagnoses. R33's last VPC Assessment was dated October 1, 2021, and was categorized as "other". R33's record lacked evidence an assessment had been completed since October 1, 2021. On January 11, 2022, at 3:45 p.m. registered nurse (RN)-C confirmed the 14-day assessment had not been completed as required for R34, and 90-day assessments had not been completed for R34, R29, R30, R26, R31, R32, R33. RN-C indicated there had been many missing assessments, and the schedule was off sync since the previous director of health services had left. RN-C stated all assessments were now scheduled to be completed on the calendar. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency, undated, noted nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition	{01620}		

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{01620}	Continued From page 12 No further information was provided.	{01620}		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (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. (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 one of seven residents' (R23) service plans were revised to reflect the current services provided. In addition, the facility failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for one of	01640		

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01640	Continued From page 13 seven residents (R23) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 11, 2022, at 11:07 a.m. unlicensed personnel (ULP)-I was observed to check R23's blood sugar. R23's Service Plan Agreement dated July 8, 2021, did not identify R23 received assistance with blood sugar checks. R23's record included a form titled Treatments or Therapy Services to be Provided dated December 15, 2021. The form identified blood sugar 4 (four) times daily by ULP. Though this form was signed by the licensee, it was not signed by the resident or resident's representative. On January 12, 2022, at 10:33 a.m. registered nurse (RN)-C stated the Treatments or Therapy Services to be Provided form was a new form developed for treatment plans. RN-C stated it was the nurse's responsibility to generate a new Service Plan Agreement to include all treatments or therapy services when changes occurred. RN-C stated blood sugar checks should be listed on the Service Plan Agreement and would require a signature from the resident or resident's	01640		

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01640	Continued From page 14 representative. RN-C verified this was lacking from R23's record. The licensee's Contents of Service Plans policy, undated, noted: all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans and any revisions to services [sic] plan will have a signature or other authentication by the facility and by the resident. No further information was provided.	01640		
{01750} SS=D	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 (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 document review, the licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions in two of two residents' records (R25 and R24) for medication administration delegated to unlicensed personnel with records reviewed.	{01750}		

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{01750}	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R25 R25's record lacked specific written instructions regarding the administration of as needed (PRN) medications. R25's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic health condition that affects how your body turns food into energy), hypertension (high blood pressure), and depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). R25's Service Plan Agreement signed July 1, 2021, indicated R24 received assistance with bathing, dressing, compression stockings, blood sugar checks, medication administration. R25's physician orders dated December 1, 2021, included, but were not limited to: - docusate sodium (constipation) 100 mg (milligrams) 1 tablet by mouth daily as needed; - milk of magnesia (constipation) 15 ml (milliliters) by mouth once daily as needed; and - nitrostat (chest pain) 0.4 mg tablet take 1 tablet sublingually (under tongue) every 5 minutes as needed.	{01750}		

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{01750}	Continued From page 16 The licensee failed to have instructions regarding when each medication for constipation (docusate and milk of magnesia) were to be given. In addition, the licensee failed to have specific written instructions for nitrostat which would include maximum of three doses, when to call a nurse, or when to call emergency personnel. On January 12, 2022, at 10:05 a.m. registered nurse (RN)-C confirmed there were no specific instructions for R25's PRN constipation medications. The nitroglycerin order should include: times 3 doses, and to contact the nurse. R24 R24's record lacked specific written instructions regarding the administration of PRN medications. R24's diagnoses included, but were not limited to, confusion/cognitive deficits and gastroesophageal reflux disease (heartburn). R24's Service Plan Agreement signed December 20, 2021, indicated R24 received assistance with bathing, dressing, grooming, compression stockings, oxygen management, toileting, and medication administration. R24's physician orders dated January 5, 2021, included, but were not limited to: - Tums (antacid) 500 mg 1 chewable tablet by mouth as needed for upset stomach - Maalox (antacid) advanced regular strength 200 mg-200 mg-20 mg/5 milliliters(ml) daily as needed take 5-15 ml by mouth as needed for upset stomach The licensee failed to have instructions regarding when each medication for upset stomach (Tums and Maalox) were to be given.	{01750}		

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{01750}	Continued From page 17 On January 11, 2021, at 2:40 p.m. RN-C confirmed there were no specific instructions for R24's PRN antacid medications. The licensee's Administration and Documentation of PRN Medications policy, undated, noted: the RN will review PRN prescriptions to ensure that the prescription clearly identifies symptoms for which the PRN is prescribed, the frequency that the PRN may be administered, the dose that may be administered, route and other pertinent information. If the parameters for the PRN medication are unclear, the RN will follow up with the prescriber to obtain the necessary clarification. No further information provided.	{01750}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for one of one medication cart 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	{01890}		

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{01890}	Continued From page 18	{01890}		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On January 10, 2022, at 3:25 p.m. a review of the assisted living medication carts was completed with registered nurse (RN)-C with the following findings:
- R16 had latanoprost eye drops dated as opened on December 8, 2021, and expired on January 5, 2022, Combigan eye drops dated as opened on December 7, 2021, and expired on January 4, 2022;
- R21 had dorzolamide-timolol dated as opened on December 7, 2021, and expired on January 4, 2022

On January 10, 2022, at approximately 3:35 p.m. RN-C stated the medications should have been removed from the cart and destroyed when expired. Staff are expected to label when opened with an open date and an expiration date. All eye drops were to be marked as expired at 28 days.

The manufacturer's instructions for latanoprost revised August 2011, noted once a bottle was opened for use, it may be stored at room temperature for six weeks.

The manufacturer instructions for Combigan revised October 2015, noted do not use the product after the expiration date marked on the bottle.

The manufacturer instructions for

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{01890}	Continued From page 19 dorzolamide-timolol eye drops dated October 2009, identified the solution can be used until the expiration date on the bottle. The facility's Storage of Medications policy dated April 25, 2017, indicated the Director of Health Services or designee will routinely check medications that are centrally stored for staff administration for expiration dates. When a dispensed medication is at or exceeds the printed expiration date, the mediation will be removed from use, new medication ordered and the tenant or tenant's responsible party will be notified as indicated. The expired medication will be disposed of per agency protocol. No further information was provided.	{01890}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

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{02240}	Continued From page 20	{02240}		
{02240} SS=A	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	{02240}		

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{02240}	Continued From page 21	{02240}		

because of a complaint.
(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and information about how to make a complaint was provided to the residents and a written acknowledgement received for one of seven residents (R24) with records reviewed.

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 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:

R24
R24 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current bill of rights, and a written acknowledgement of receipt.

On January 12, 2022, at 11:17 a.m. registered nurse (RN)-D brought in a tracking sheet she had been utilizing for tracking of the bill of rights. The tracking sheet identified R24's was missing. RN-D verified R24's record lacked evidence of

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{02240}	Continued From page 22 acknowledgement of receipt of the current bill of rights. The licensee's Notice of Resident Rights policy, undated, noted: written acknowledgement of the resident's receipt of the assisted living bill or [sic] rights will be obtained. If a written acknowledgement of receipt of the bill of rights cannot be obtained, why an acknowledgement cannot be obtained will be documented. Acknowledgement of receipt or reason why receipt cannot be obtained will be in the resident's record. No further information was provided.	{02240}		

Electronically Delivered

December 9, 2021

Administrator
VP at Goldfinch Estates LLC
850 Goldfinch Street
Fairmont, MN 56031

RE: Project Number(s) SL30399015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 21, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

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

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30399	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VP AT GOLDFINCH ESTATES LLC	850 GOLDFINCH STREET FAIRMONT, MN 56031

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30399015 On October 18, 2021 through October 21, 2021, surveyors of this Department's staff visited the above Assisted Living with Dementia Care licensed provider, and the following correction orders are issued. At the time of the survey, there were 119 residents receiving services under the assisted living with dementia care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	0 250		

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0 250	Continued From page 2 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to meet the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, developed and implemented current policies and procedures as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the facility failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency	0 250		

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0 250	Continued From page 3 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; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - 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; and - medication and treatment management Refer to licensing order at Statute 144G.41 Subd. 3. The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. Refer to licensing order at Statute 144G.42 Subd. 6 and 626.557 Subd. 3. Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R6) with record reviewed. Refer to licensing order at Statute 144G.42 Subd. 9. Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 250		

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0 250	Continued From page 4 for Disease Control and Prevention (CDC) which included a facility TB risk assessment. Refer to licensing order at Statute 144G.63 Subd. 2. The licensee failed to ensure four of four employees (unlicensed personnel (ULP)-A and ULP-E, licensed practical nurse (LPN)-F, and registered nurse (RN)-D) received orientation to assisted living facility licensing requirements and regulations Refer to licensing order at Statute 144G.70 Subd. 2. The licensee failed to complete a 14 day assessment on two of two residents (R3 and R7) with records reviewed. In addition, the licensee failed to complete 90 day assessments for two of two residents (R2 and R6), and a change of condition assessment for one of one resident (R12) not resulting in significant injury. Refer to licensing order at Statute 144G.71 Subd. 1. The licensee failed to implement their policy to ensure the security and accountability of controlled substances for one of two locked narcotic storage areas. Refer to licensing order at Statute 144G.71 Subd. 7. The licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for medication administration delegated to unlicensed personnel for one of three residents (R4). Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medication orders were transcribed to the medication administration record (MAR) accurately for one of nine residents (R5).	0 250		

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0 250	Continued From page 5 Refer to licensing order at Statute 144G.71, Subd. 13. The licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of eight residents (R5). Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure medications were not expired for one of one medication cart. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R10). Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to have on the service plan a written statement of the treatment or therapy services provided for three of seven (R3, R4 and R6) Refer to licensing order at Statute 144G.72 Subd. 4. The licensee failed to accurately specify written instructions for each resident and document in one of one resident's record (R4) who received an altered texture diet. Refer to licensing order at Statute 144G.72 Subd. 6. The licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of eight residents (R5) receiving treatments.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 144G.90 Subdivision 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and information about how to make a complaint was provided to the residents and a written acknowledgement received for five of seven residents (R1, R2, R4, R5, R9) with records reviewed. Refer to licensing order at Statute 144G.91, Subd. 4. The licensee failed to provide care in accordance with accepted healthcare standards for one of one resident (R6) by completing a change of condition assessment and failed to create and implement interventions which resulted in serious injury. Refer to licensing order at Statute 144G.91, Subd. 7. The licensee failed to provide a dignified dining experience for one of one resident (R4) observed during dining. Thirty-one (31) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.95. During the entrance conference on October 18, 2021, at 11:25 a.m. the licensed assisted living director in residence (LALDIR) confirmed she was responsible for and participated in the day-to-day operations. LALDIR stated she was familiar with the Assisted Living with Dementia Care licensing rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 250		

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0 250	Continued From page 7 (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers and the public as	0 470		

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0 470	Continued From page 8 required, potentially affecting all of 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: The census at the time of the survey was 119 residents. The licensee failed to have the daily work schedule posted in a central location accessible to staff, residents, volunteers and the public. During the entrance conference on October 18, 2021, at approximately 12:00 p.m. registered nurse (RN)-C stated the staffing plan was posted on the "radio room" door. On October 11, 2021, at approximately 2:00 p.m. during facility tour, the staffing plan was located on a door to a room on the second floor. The door was labeled "storage". RN-C stated the room was used to store the med cart and radios for staff. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 9	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 119 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 480		

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0 480	Continued From page 10 The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Report dated October 19, 2021. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 11	0 510		

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).

On October 18, 2021, at approximately 12:48 p.m. during facility tour with licensed assisted living director in residence (LALDIR) and registered nurse (RN)-C, multiple residents were observed sitting in the main entrance of the lobby area. Though both the LALDIR and RN-C wore medical grade facemasks, neither wore eye protection. While touring in the memory care unit, RN-D was observed wiping R9's fingers in the dining room. RN-D was not wearing eye protection.

On October 19, 2021, at 12:23 p.m. LALDIR entered R5's room with the surveyor and the engineer. R5 was present in the room. The LALDIR was wearing a medical grade mask, but no eye protection.

On October 20, 2021, at approximately 2:32 p.m. RN-D stated staff should wear a surgical face mask and eye protection anytime they are having direct contact with residents.

On October 21, 2021, at 11:54 a.m. RN-C stated staff should have eye protection on when near residents. RN-C indicated this would include the main lobby where residents sit, dining areas, during cares, in resident apartments and upon entrance to memory care unit so assistance may be provided as needed.

The Minnesota Department of Health Infection Prevention and Control: COVID-19 electronic guidance for infection prevention and control in

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0 510	Continued From page 12 health care settings, dated August 2, 2021, indicated MDH recommends eye protection for all health care workers (HCW) in all resident care areas and when providing direct care. The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The licensee's policy lacked instruction on PPE use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 620		

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0 620	Continued From page 13 licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R6) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses included, but were not limited to, dementia (memory loss), osteoporosis (weakening of the bones), major depressive disorder, and history of head injury. A Resident Incident Report dated September 7, 2021, at 7:30 p.m. identified R6 was found on the common living room floor with her wheelchair folded next to her. The form further indicated initial injuries sustained from the fall was bruising and skin tear on her right eye. The registered nurse (RN)-D was notified. The incident investigation section was not completed. A progress note dated September 8, 2021, indicated R6 was sent to the emergency room at 6:07 a.m. with complaints of pain, bruising, and inability to move her left arm. R6 returned to the facility with diagnoses of fractured clavicle (collar bone) and broken rib. An After Visit Summary form dated September 8, 2021, indicated injuries of contusion face,	0 620		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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VP AT GOLDFINCH ESTATES LLC	850 GOLDFINCH STREET FAIRMONT, MN 56031

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0 620	Continued From page 14 abrasion left eyebrow, fractured left clavicle, fractured left rib, and separation acromioclavicular (joint at the top of the shoulder). On October 20, 2021, at approximately 5:00 p.m. RN-D stated she did not report R6's incident to MAARC because she "thought" she knew what happened. She further stated the incident was unwitnessed with a serious injury but did not have an internal investigation available for review. The licensee's Vulnerable Adult Reporting and Investigation Policy dated March 1, 2018, indicated agency staff is required to report to the MAARC when a client has sustained a physical injury which is not reasonably explained. Such physical injuries may include, but are not limited to, unexplained bruises, skin tears, lacerations, or fractures. Staff that observes an unexplained physical injury will immediately notify the DOHS (director of health services) or nursing in charge, who will conduct an internal investigation, to determine whether the injury is unexplained and whether a report to MAARC is required. If it is unclear whether maltreatment occurred, the DOHS, nurse in charge, or ED will immediately begin investigating the incident. If within the 24 hours following the initial incident report and it is still unsure whether reportable maltreatment has occurred, an oral report to MAARC will be made. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 15 (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 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 observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for five of six residents (R2, R3, R4, R5, and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 On October 19, 2021, at 1:11 p.m. unlicensed personnel (ULP)-A was observed to provide wound care to R2. R2's Service Plan Agreement signed July 1,	0 630		

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0 630	Continued From page 16 2021, indicated R2 received assistance with meals, housekeeping, laundry, and wound care. R2's Individualized Abuse Prevention Plan dated June 6, 2020, noted vulnerabilities included, but were not limited to, endurance and strength; however, the plan lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 On October 19, 2021, at 11:44 a.m. ULP-A was observed providing insulin administration to R3. R3's Service Plan Agreement signed August 2, 2021, indicated R3 received meals, medication services and support services. R3's Individualized Abuse Prevention Plan signed August 6, 2021, noted vulnerabilities included, but were not limited to, anxiety/depression/mental illness and the ability to evacuate in an emergency; however, the plan lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4 On October 19, 2021, at approximately 9:59 a.m. licensed practical nurse (LPN)-F was observed to do wound care to R4's left heel. R4's Service Plan Agreement signed September 21, 2021, indicated R4 received assistance with bathing, dressing, grooming, compression stockings, toileting, and medication administration.	0 630		

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0 630	Continued From page 17 R4's Individualized Abuse Prevention Plan dated June 17, 2021, noted vulnerabilities included, but were not limited to, the following: - ability to give accurate information consistently; - ability to ambulate safely with/without assistive devices; - endurance/strength; - ability to follow directions consistently; and - ability to report abuse or neglect. R5 On October 19, 2021, at approximately 11:51 a.m. R5 was observed sitting in a wheelchair in her room with oxygen on via nasal cannula. R5 stated staff assisted with her oxygen needs. R5's Service Plan Agreement signed September 22, 2021, indicated R5 received assistance with bathing, dressing, grooming, toileting, oxygen management, and medication administration. R5's Individualized Abuse Prevention Plan dated July 12, 2021, noted vulnerabilities included, but were not limited to, the following: - orientation to time, place and person; - anxiety/depression/mental illness; - ability to give accurate information consistently; - ability to ambulate safely with/without assistive devices; - endurance/strength; - able to follow directions consistently; and - ability to report abuse or neglect. On October 20, 2021, at approximately 1:20 p.m. registered nurse (RN)-D confirmed R4 and R5's abuse prevention plan lacked information for the statements of specific measures to be taken related to the identified vulnerabilities.	0 630		

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0 630	Continued From page 18 R6's diagnoses included, but were not limited to, dementia (memory loss), osteoporosis (weakening of the bones), major depressive disorder, and history of head injury. R6's Service Plan Agreement signed on July 8, 2021, indicated services included medication administration, bathing, grooming, dressing, ambulation, and toileting. R6's Individualized Abuse Prevention Plan dated July 30, 2021, indicated R6's areas of vulnerability; however, the form lacked the following required content: - the person's susceptibility to abuse by other individuals - 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 The facility's Individual Abuse Prevention Plans policy dated August 1, 2021, noted the individual abuse prevention plan would include specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640		

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0 640	Continued From page 19 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers to include 911 in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 119 residents receiving assisted living care services, 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: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and	0 640		

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0 640	Continued From page 20 - post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557; and - provide reasonable accommodation with information and notices in plain language On October 18, 2021, at approximately 11:00 a.m. upon arriving at the establishment, an observation was made of the main entry area and memory care entry lacked evidence of the required posted information. On October 21, 2021, at approximately 10:15 a.m. registered nurse (RN)-C and the licensed assisted living director in residence (LALDIR) confirmed the required content noted above had not been posted in a conspicuous area available to all residents, staff, and visitors. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 21 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. 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 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 October 19, 2021, at 12:40 p.m. registered nurse (RN)-C confirmed the licensee had not completed a TB risk assessment as required. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July	0 660		

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0 660	Continued From page 22 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The facility's TB Prevention and Control policy dated August 1, 2021, indicated the RN was responsible for establishing and maintaining the TB prevention and control program, including: completion of a written TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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	0 680		

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0 680	Continued From page 23 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 complete a facility risk assessment and failed to have a comprehensive program for emergency preparedness that included all required components. 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: The licensee's emergency preparedness plan provided to the surveyors, was a number of documents and policies contained in a three-ringed binder. The licensee's plan lacked the following required content: - current, all-hazards approach facility assessment; - description of the population served by licensee; - process for emergency preparedness (EP) cooperation with state and local EP	0 680		

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0 680	Continued From page 24 officials/organizations; - subsistence needs for staff and residents during emergency situation; - procedure for tracking staff and residents; - development of all policies/procedures, based on assessment; and additional policies for: - sheltering in place; - handling and use of volunteers; - development of a communication plan, including primary and alternate means for communication; - methods for sharing information/family notifications; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On October 18, 2021, at 2:02 p.m. the licensed assisted living director in residence (LALDIR) stated the risk assessment was not completed. She had started redoing all of the emergency preparedness policies, but it was a work in progress and had not been completed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	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;	0 730		

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0 730	Continued From page 25 (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 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.	0 730		

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0 730	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the client record included a discharge summary for one of one resident (R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R10's diagnoses included, but were not limited to, diaphragmatic hernia (a birth defect where there is a hole in the large muscle that separates the chest from the abdomen), gastroesophageal reflux disease (digestive disorder causing heartburn), high cholesterol, hypertension (high blood pressure), overactive bladder, and anxiety. R10 discharged from the licensee on September 10, 2021. R10's record lacked a discharge summary. On October 19, 2021, at 2:07 p.m. registered nurse (RN)-D confirmed a discharge summary had not been completed for R10. The facility Discharge Summary policy dated August 1, 2021, noted a discharge summary would be written at the time of discharge and would include a summary of the resident's stay.	0 730		

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0 730	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents as required by MN Statute 144G.45 subd.2(a)(4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 800		

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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
0 800	Continued From page 28 On the facility tour with the licensed assisted living director in residence (LALDIR) between 11:00 a.m. and 12:55 p.m. on October 19, 2021, it was observed that there was a baseboard heater with a missing cover plate with exposed wiring in the corridor by the LALDIR office. This deficient condition was visually verified by the LALDIR accompanying on the tour. There was an observation of a hole in the fire rated sheetrock wall with exposed and uncapped electrical wires from where an electrical box had been removed in the 2nd floor South Mechanical Room. This was a locked room, so did pose a reduced risk to residents. This deficient condition was visually verified by the LALDIR accompanying on the tour. There was an observation of a large hole in the fire rated sheetrock ceiling in the Mechanical Room (Boiler Room) in the Memory Care wing. This deficient condition was visually verified by the LALDIR accompanying on the tour. There was an observation of a large hole in the fire rated sheetrock ceiling in the 1st floor Maintenance Room by the kitchen and dining room. This deficient condition was visually verified by the LALDIR accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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0 810	Continued From page 29 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to provide fire safety and evacuation training at least twice per year after hire to employees, failed to have fire safety and evacuation plans readily available at all times	0 810		

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0 810	Continued From page 30 within the facility, failed to provide fire safety and evacuation training once per year to residents who are capable of assisting in their own evacuation, and failed to require evacuation drills twice per year per shift with at least one evacuation drill every other month, as required by MN Statute 144G.45 Subd.2 (c), (d), (e), and (f). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 19, 2021, between 10:20 a.m. and 11:00 a.m., an interview and record review was conducted with the licensed assisted living director in residence (LALDIR) on fire safety, evacuation training, and drills for the employees and for residents who are capable of assisting in their own evacuation. Based on this record review, the facility did not have records of providing employees with fire safety and evacuation training at least twice per year after hire. An interview conducted with LALDIR indicated that the facility does not currently have a process in place for follow up fire safety and evacuation training for employees. An interview and record review was also conducted on the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 31 Based on this record review, a fire safety and evacuation plan was not readily available in records. An interview conducted with LALDIR indicated that the fire safety and evacuation plan was posted on the back of the resident doors within the individual units. On a facility tour with the LALDIR between 11:00 a.m. and 12:55 p.m. on October 19, 2021, it was observed the fire safety and evacuation plans were not readily available and missing from all doors checked in the resident units. An interview with LALDIR indicated that some of the doors had been repainted upon vacancy, but was not aware the plans had been removed or where they had been relocated to. An interview and record review was also conducted on providing training for residents on the proper actions to take in the event of a fire to include movement, evacuation, or relocation at least one time per year. An interview conducted with LALDIR indicated that they had not provided specific training to residents at this time and they were working on putting a program into place. An interview and record review was also conducted with LALDIR on evacuation drills for employees. Based on this record review, the facility had no documentation indicating that they had conducted any evacuation drills for employees. An interview conducted with LALDIR indicated that the licensee had not performed evacuation drills at this time and they were working on putting a program into place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01470	Continued From page 32	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 33 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four employees (unlicensed personnel (ULP)-A and ULP-E, licensed practical nurse (LPN)-F, and registered nurse (RN)-D) received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01470		

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01470	Continued From page 34 ULP-A, ULP-E, LPN-F, and RN-D's training records lacked evidence to indicate the employees had received orientation to include the following topics: - an overview of Chapter 144G; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-A, ULP-E, LPN-F, and RN-D began providing assisted living services for the licensee on August 1, 2021. The employees' records lacked the above required content. On October 20, 2021, at approximately 1:25 p.m. RN-D confirmed the employees had not received	01470		

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01470	Continued From page 35 the above noted required training. On October 21, 2021, at approximately 11:54 a.m. the licensed assisted living director in residence (LALDIR) confirmed no employees had received the above noted required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to complete a 14 day assessment on two of two residents (R3 and R7) with records reviewed. In addition, the licensee failed to complete 90 day assessments for one of one residents (R2), and a change of condition assessment for one of one resident (R12) not resulting in significant injury. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). R3 R3 was admitted on August 6, 2021. R3's Service Plan dated August 2, 2021, identified R3 received medication management services, meal plan, and "support services". R3's "VPC Assessment" (identified as a comprehensive assessment) was dated August 6, 2021, and was categorized as the admission assessment. R3's record lacked evidence a 14 day assessment had been completed. On October 19, 2021, at 11:44 a.m. unlicensed personnel (ULP)-A was observed checking R3's blood glucose and administration of insulin. R7	01620		

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01620	Continued From page 37 R7 was admitted on August 2, 2021. R7's Service Plan dated July 31, 2021, identified R7 received meal plan and "support services". The service plan failed to identify a description of the services to be provided, the frequency of each service, and the identification of staff or categories of staff who will provide the services. R7's Service Received record, dated October 2021, identified R7 received house keeping services. R7's "VPC Assessment" (identified as a comprehensive assessment) was dated July 30, 2021, and was categorized as the admission assessment. R7's record lacked evidence a 14 day assessment had been completed. R2 R2 was admitted on October 1, 2018. R2's Service Plan dated July 1, 2021, identified R2 received housekeeping, laundry, meals, and wound care services. On October 19, 2021, at 1:11 p.m. ULP-A was observed providing a dressing change for R2. R2's "VPC Assessment" (identified as a comprehensive assessment) was dated May 24, 2021, and was categorized as a 90 day assessment. R2's record lacked evidence a 90 day assessment had been completed since the May 24, 2021 assessment (148 days). On October 19, 2021, at 3:28 p.m. registered nurse (RN)-C confirmed the 14 day assessments had not been completed for R3 and R7 and a 90 day assessment had not been completed for R2.	01620		

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01620	Continued From page 38	01620		

R12
R12's diagnoses included but were not limited to, dementia, type 2 diabetes, and diabetic neuropathy.

R12's Service Plan Agreement dated October 1, 2021, indicated services included assist of one with dressing, bathing, medication administration, transferring, and toileting.

Resident Incident Reports for R12 indicated he had sustained falls on:
- August 17, 2021, at 11:50 a.m. indicated resident laying on the ground in bedroom and sustained a skin tear to his left hand. Fall assessment was requested, but not provided. There was no incident investigation completed or documented and the appropriate medical professional or family were not notified.
- September 23, 2021, at 3:30 a.m. indicated a witnessed fall to the floor with no injuries. Fall assessment was requested, but not provided. There was no incident investigation completed or documented and the appropriate medical professional was not notified.

During an interview on October 20, 2021, at 1:25 pm, RN-D verified R12's record lacked incident investigations, fall assessments, safety interventions, and physician notification. She further stated, "we talked bout them but nothing was written down".

The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License, undated, identified "Nursing

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01620	Continued From page 39 assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition." "A RN will complete the following comprehensive nursing assessments of the resident ' s physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition 2. A RN will complete assessments as indicated by individual resident circumstances" "On-Going Assessments of Residents: a. The RN will re-assess each resident on an on-going basis. b. The RN will determine the frequency of re-assessments based on the resident ' s needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. c. The RN will reassess the resident if the resident has a change in condition" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=A	144G.70 Subd. 4 Service plan, implementation, and revisions t (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	01640		

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01640	Continued From page 40 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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a signed service plan for one of eight residents (R12) with records reviewed 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 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: R12's Service Plan Agreement dated October 1, 2021, was not signed by the resident, responsible person, or nurse.	01640		

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01640	Continued From page 41 On October 20, 2021, at approximately 1:25 p.m. RN-D verified the above noted service plan was not signed. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650		

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01650	Continued From page 42 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have all required content on the service plan for two of eight residents (R3 and R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted on August 6, 2021. R3's Service Plan dated August 2, 2021, identified R3 received medication management services, meal plan, and "support services". The service plan failed to identify a description of the services to be provided, the frequency of each service, and the identification of staff or categories of staff who will provide the services. On October 19, 2021, at 11:44 a.m. ULP-A was observed checking R3's blood glucose and administration of insulin. R7 R7 was admitted on August 2, 2021. R7's Service Plan dated July 31, 2021, identified R7 received meal plan and "support services". The service plan failed to identify a description of	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01650	Continued From page 43 the services to be provided, the frequency of each service, and the identification of staff or categories of staff who will provide the services. On October 19, 2021, at 3:28 p.m. registered nurse (RN)-C confirmed the service plan for R3 and R7 failed to identify a description of the services to be provided, the frequency of each service, and the identification of staff or categories of staff who will provide the services. She was unaware the required information had not printed in the service plan. The licensee's "Contents of service plan" policy, undated, identified "service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01690 SS=E	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop,	01690		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01690	Continued From page 44 implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement their policy to ensure the security and accountability of controlled substances for one of two locked narcotic storage areas (memory care medication room). This had the potential to affect all residents and staff in the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01690		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01690	Continued From page 45 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 11:25 a.m. the licensed assisted living director in residence (LALDIR) and registered nurse (RN)-C confirmed the facility provided medication management services. The licensee lacked evidence of maintaining a consistent security and accountability of controlled medications. On October 19, 2021, at approximately 2:45 p.m. the locked medication room in the memory care unit was observed with licensed practical nurse (LPN)-F and RN-D. There was a locked corner cupboard identified by LPN-F as housing the narcotic box. Inside the locked cupboard was a locked safe requiring a code. LPN-F stated only licensed staff have access to this cupboard and safe. LPN-F further indicated this locked safe included both active and discontinued controlled medications, but was not routinely reconciled. The locked safe contained the following schedule 1-5 drugs (medications with a high to low potential for abuse): R18: 30 oxycodone (schedule II pain narcotic) 5 milligram (mg) tablets, two bottles containing 28 milliliters (ml) of hydromorphone (schedule II pain narcotic) 1 mg/1 ml, 30 ml Ketamine (schedule III anesthetic);	01690		

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01690	Continued From page 46 R20: 14 lorazepam (schedule IV sedative) 0.5 mg tablets and another card of 6 lorazepam 0.5 mg tablets; R9: 10 ml of hydromorphone 1 mg/1 ml solution; R11: 30 ml of hydromorphone 1 mg/1 ml, 30 lorazepam 0.5 mg tablets; R8: 28 Tramadol (schedule IV pain narcotic) 50 mg; R17: two lorazepam 1 mg tablets and 92 hydrocodone/acetaminophen 5-325 mg; R4: 12.5 ml hydromorphone 1 mg/1 ml and two 30 ml bottles of hydromorphone 1 mg/1 ml; R6: 30 ml bottle of hydromorphone 1 mg/1 ml, 30 lorazepam 0.5 mg tablets. On top of the locked safe were two bound yellow notebooks labeled Controlled Substance Drug Record. The notebooks identified the resident, date received, physician, medication name, dose, RX#, nurse receiving and second nurse signature, directions for use, amount received. Though medications had been signed out as recently as October 13, 2021, no signatures were documented to verify the narcotics had been reconciled. LPN-F verified the narcotics kept on the medication cart were counted shift to shift; however, not the narcotics kept in the locked narcotic box within the medication room. Both LPN-F and RN-D verified the risk of diversion existed, and indicated the medications should be accounted for each change of shift. The facility's Controlled Substances/Schedule II Drugs policy dated March 15, 2018, indicated staff will count controlled drugs at the end of each shift. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the director of health services or	01690		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01690	Continued From page 47 nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01750 SS=D	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 (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 document review, the licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions in one of three resident's records (R4) for medication administration delegated to unlicensed personnel with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01750		

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01750	Continued From page 48 of staff are involved, or the situation has occurred only occasionally). The findings include: R4's record lacked specific written instructions regarding the administration of as needed (PRN) medications. R4's diagnoses included, but were not limited to, Alzheimer's disease and diabetes. R4's Service Plan Agreement signed September 21, 2021, indicated R4 received assistance with bathing, dressing, grooming, compression stockings, toileting, and medication administration. R4's physician orders dated October 13, 2021, included, but were not limited to: -acetaminophen (for pain) 650 milligrams (mg) suppository every 4 hours PRN per rectum insert 1 suppository (650 mg total) into the rectum every 4 hours PRN for pain or fever (if unable to swallow tab form); -hydromorphone (narcotic pain medicine) 1 mg/milliliter (ml) solution every 2 hours as needed take 0.5 ml by mouth every 2 hours as needed for pain; -haldol 2 mg/ml take 1 ml by mouth every hour as needed for agitation; and -lorazepam 0.5 mg take 1 table by mouth every 4 hours as needed for anxiety. The licensee failed to have instructions regarding when each medication for pain (acetaminophen and hydromorphone) and for agitation/anxiety (haldol and lorazepam) were to be given. On October 21, 2021, at 9:50 a.m. unlicensed	01750		

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01750	Continued From page 49 personnel (ULP)-G stated each resident was different so you get to know what works for them and then administer it if within the appropriate time frame for administration. On October 21, 2021, at 10:00 a.m. registered nurse (RN)-D confirmed there were no specific instructions for R4's PRN pain and agitation/anxiety medications. A policy was requested, but was not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication orders were	01760		

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01760	Continued From page 50 transcribed to the medication administration record (MAR) accurately for one of nine residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's hospital discharge physician orders dated October 6, 2021, included, but were not limited to: - acetaminophen (pain reliever) 500 milligrams (mg); take 2 (two) tablets by mouth every 6 (six) hours as needed for mild pain or score 1-3 of 10 pain scale; - albuterol (opens airways in the lungs) 90 micrograms (mcg)/actuation inhaler; inhale 2 (two) puffs every 4 (four) hours as needed for wheezing; and - mintox maximum strength 400-400-40 mg/5 milliliter (ml) suspension; take 10 ml by mouth every 6 (six) hours as needed for indigestion or heartburn. R5's medication administration record (MAR) dated October 2021, included, but was not limited to: - acetaminophen 500 mg; take 2 tablets by mouth every 6 hours as needed for pain; - albuterol 90 mcg inhaler; inhale 2 puffs every 4 hours as needed for shortness of breath do not give if resident had neb within 4 hours for shortness of breath.	01760		

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01760	Continued From page 51 - mintox maximum strength suspension; take 10 ml four times daily as needed for stomach upset. - Nystatin (anti-fungal) 100000 unit/gram powder; use to reddened skin two times daily as needed. On October 21, 2021, at approximately 10:04 a.m. registered nurse (RN)-D stated the orders should have been transcribed in the MAR as written from physician orders dated October 6, 2021, and verified the medication listed above had not been transcribed as ordered, nor had the Nystatin been reordered. The facility's Medications & Treatments policies dated August 1, 2021, lacked instruction on transcribing orders. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of eight residents (R5) with records reviewed.	01820		

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01820	Continued From page 52 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's record lacked prescriber's orders for a medication administered by the facility. R5's Service Plan Agreement dated September 22, 2021, indicated the resident received services including bathing, dressing, grooming, oxygen and medication administration. R5's October 2021, medication administration record (MAR) indicated the following medication had been administered on October 10, 2021, and October 14, 2021, without current signed physician orders: - Senna (laxative) 8.6 milligram (mg) tablet; take 1 tablet every day as needed. On October 21, 2021, at approximately 10:04 a.m. registered nurse (RN)-D verified R5's record lacked a prescriber order for the Senna. RN-D stated the resident had returned from the hospital on October 6, 2021, and had previously had an order for Senna as needed. RN-D stated R5's hospital discharge orders should have been reconciled with previous orders and the order for Senna as needed should have been clarified with the primary physician to ensure it was to continue as a current order for R5.	01820		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01820	Continued From page 53 The licensee's Resident Records policy dated August 1, 2021, identified the resident record will contain orders or prescriptions for medications, treatments or therapies that the agency will be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for one of one medication cart reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 54 On October 19, 2021, at approximately 2:26 p.m. the memory care locked medication cart was reviewed with licensed practical nurse (LPN)-F. R19's Latanoprost 50 micrograms/milliliter eye drops, had a date open label of August 16, 2021; however, the eye drops lacked a date when the eye drops would expire. R11's Timolol maleate 0.5% eye drops, had a date open label of August 16, 2021; however, the eye drops lacked a date when the eye drops would expire. On October 19, 2021, at approximately 2:26 p.m. LPN-F confirmed both eye drops were expired and should not have been in the medication cart. LPN-F stated normally the eye drops are only open for 30 days unless specified sooner by pharmacy or manufacturer. On October 19, 2021, registered nurse (RN)-C stated eye drops were to be dated when open and expire following manufacturer instructions. The manufacturer's instructions for Latanoprost revised August 2011, noted once a bottle is opened for use, it may be stored at room temperature for 6 weeks. R19's Latanoprost was expired as of September 27, 2021, (more than 3 weeks prior). The manufacturer's instructions for timolol maleate dated February 2009, noted the eye drop would be used within one month after the foil package has been opened. R11's timolol mealeate was expired as of September 16, 2021, (more than 4 weeks prior).	01890		

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01890	Continued From page 55 The facility's Storage of Medications policy dated April 25, 2017, indicated the Director of Health Services or designee will routinely check medications that are centrally stored for staff administration for expiration dates. When a dispensed medication is at or exceeds the printed expiration date, the mediation will be removed from use, new medication ordered and the tenant or tenant's responsible party will be notified as indicated. The expired medication will be disposed of per agency protocol. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 56 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R10) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R10's record lacked documentation of medication disposition upon the resident's discharge. R10 was discharged from the licensee on September 10, 2021, to a hospital where she later transferred to a nursing home. R10's diagnoses included, but were not limited to, diaphragmatic hernia (a birth defect where there is a hole in the large muscle that separates the chest from the abdomen), gastroesophageal reflux disease (digestive disorder causing heartburn), high cholesterol, hypertension (high blood pressure), overactive bladder, and anxiety.	01910		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01910	Continued From page 57 R10's physician orders were requested, but not provided. R10's medication administration record (MAR) dated September 2021, included but was not limited to, the following medications: one mild-moderate pain reliever, two anti-hypertensive medications (to reduce blood pressure), one antilipemic (to lower cholesterol), one lubricating eye drop, two inhalers, two vitamins, one sedative, one sleep aid supplement, one proton pump inhibitor (to decrease stomach acid), one over active bladder medication, one antacid, two antidiarrheals, pain relieving gel, one antifungal powder, and two for constipation. R10 's record had a Medication Disposition/Disposal Record that included two eye drops and two inhalers disposed of on September 10, 2021, and one bottle of liquid antacid, one bottle of powder mixture for constipation, and one roll on pain medication that was disposed of on September 20, 2021; however, R10's record lacked evidence of documentation of R10's disposition of the remaining medications to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 19, 2021, at approximately 2:07 p.m. registered nurse (RN)-D confirmed R10 had received medication administration as part of their services, and verified R10's record did not include documentation of medication disposition as noted above. RN-D stated R10's medications were still in the medication room because the RX Destroyer (a medication destroyer system) was	01910		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01910	Continued From page 58 full and management was working on getting a different system. RN-D further added, normally medications were destroyed as soon as possible and verified R10's medications should not still be in the medication room. The facility's Disposition or Disposal of Medication policy dated August 1, 2021, noted staff will document the disposition or disposal of medications in the resident's record. Documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

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01940	Continued From page 59 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to have on the service plan a written statement of the treatment or therapy services provided for three of seven (R3, R4 and R6) residents receiving treatments with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 11:25 a.m. registered nurse (RN)-C confirmed the licensee provided treatment and therapy services to residents as	01940		

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01940	Continued From page 60 prescribed. R3 R3 was admitted on August 6, 2021. R3's "VPC Assessment" (identified as a comprehensive assessment) was dated August 6, 2021, and was categorized as the admission assessment. The assessment identified she received blood glucose checks. R3's service plan dated August 2, 2021, identified R3 received medication management services, meal plan, and "support services". The service plan failed to identify the treatment of blood glucose monitoring. On October 19, 2021, at 11:44 a.m. unlicensed personnel (ULP)-A was observed checking R3's blood glucose and administer insulin. On October 19, 2021, at 3:28 p.m. RN-C confirmed the service plan for R3 failed to identify the treatment of blood glucose monitoring. R4 R4's diagnoses included, but were not limited to, Alzheimer's disease and diabetes. R4's Service Plan Agreement signed September 21, 2021, indicated R4 received assistance with bathing, dressing, grooming, compression stockings, toileting, weekly nail care, vital signs, weight monitoring, and medication administration. R4's service plan did not contain a written statement for the treatment services being provided, which included wound care, blood glucose monitoring, and modified diet.	01940		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01940	Continued From page 61 R4's prescriber orders dated October 13, 2021, included an order for wound treatment to left heel wound, blood glucose checks three times daily, and a diet order for nectar thick liquids (liquid thicker than water, fall slowly from a spoon) and pureed (modified diet in which all foods have a soft, pudding-like consistency). On October 19, 2021, at 9:59 a.m. licensed practical nurse (LPN)-F was observed doing wound care and a dressing change to R4's left heel wound. On October 19, 2021, at 11:36 a.m. ULP-E stated R4's blood sugar check had just been completed and it was 175. On October 19, 2021, at 12:08 p.m LPN-F was observed to stand in kitchenette next to R4 and feed him spoonfuls of pureed food and nectar thick liquids. On October 20, 2021, at 1:20 p.m. RN-D confirmed R4's service plan did not contain a written statement of treatment services that included wound care, blood glucose monitoring, and modified diet. R6 R6's diagnoses included, but were not limited to, dementia (memory loss), osteoporosis (weakening of the bones), major depressive disorder, and history of head injury R6's Service Plan Agreement signed on July 8, 2021, indicated services included medication administration, bathing, grooming, dressing, ambulation, and toileting. It failed to address a diet modification and use of a sling.	01940		

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01940	Continued From page 62 R6 sustained a fractured clavicle and rib resulting in a physician's order dated September 8, 2021, instructed R6 to wear a sling on her arm at all hours of the day. R6's prescriber orders dated September 22, 2021, included an order for and a diet order for honey thick liquids (liquid thicker than water) and pureed mechanical soft diet (texture-modified diet for people who have difficulty swallowing). On October 19, 2021, at 12:15 p.m. R6 was observed sitting at a table in a wheelchair with a pureed meal in front of her. On October 20, 2021, at approximately 1:25 p.m. RN-D verified R6 received a pureed diet with honey thickened liquids for all food and fluid intake. She also verified the service plan did not contain the sling or the modified diet. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, identified "Treatments or therapy tasks may be delegated or assigned by a Licensed Health Professional to unlicensed personnel according to the Licensed Health Professional ' s applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional must: a. Develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes 144.4793, Subd. 3. b. Instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the unlicensed personnel have demonstrated	01940		

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01940	Continued From page 63 the ability to competently follow the procedures; c. Develop written specific instructions for each resident and document those instructions in the resident ' s record; and d. Communicated with the unlicensed personnel about the individual needs of the resident"	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and (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 accurately specify written instructions for each resident and document in one of one resident's record (R4) who received an altered texture diet.	01950		

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01950	Continued From page 64 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included, but were not limited to, Alzheimer's disease and diabetes. R4's Service Plan Agreement signed September 21, 2021, indicated R4 received assistance with bathing, dressing, grooming, compression stockings, toileting, and medication administration. R4's prescriber orders dated October 13, 2021, included a diet order for nectar thick liquids (liquid thicker than water, fall slowly from a spoon) and pureed diet (modified diet in which all foods have a soft, pudding-like consistency). R4's Medication Administration Record (MAR) dated October 1, 2021 through October 18, 2021, directed for bedtime snack: "Please give resident a bedtime snack. Nutrigrain bar or a sandwich, something like that to sustain his blood sugar through the night." R4's record lacked specific written instructions to include appropriate diet texture snacks. On October 21, 2021, at approximately 11:39 a.m. registered nurse (RN)-D confirmed R4's	01950		

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01950	Continued From page 65 record did not have specific instructions for altered diet type and not all staff would knew he required a pureed diet with nectar thick liquids. On October 21, 2021, at approximately 12:03 p.m. RN-C further confirmed specific instructions should be identified on MAR to ensure staff were providing the correct snacks. The facility's Delegation of Nursing Tasks policy dated August 1, 2021, noted treatment or therapy tasks my be delegated to unlicensed personnel (ULP). When a treatment or therapy is delegated or assigned to ULP, the RN must develop written specific instructions for each resident and document those instructions in the residents' record; and communicate with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01970		

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01970	Continued From page 66 licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of eight residents (R5) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 19, 2021, at approximately 11:51 a.m. R5 was observed sitting in a wheelchair in her room with oxygen on at 2 liters/minute via nasal cannula. R5 stated staff assisted with her oxygen needs. R5's diagnoses included, but were not limited to, severe chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow and makes it difficult to breathe) and chronic hypoxic and hypoventilatory respiratory failure (lung failure with low blood oxygen levels). R5's Medication/Treatment Management plan dated October 6, 2021, indicated the resident's services included oxygen therapy. R5's medical record lacked evidence of a prescriber order for the oxygen. On October 21, 2021, at approximately 10:04 a.m. registered nurse (RN)-D verified R5's record lacked a prescriber order for the oxygen. RN-D	01970		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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01970	Continued From page 67 stated the resident had returned from the hospital on October 6, 2021, and previously had oxygen orders. RN-D stated R5's orders should have been reconciled and the oxygen order should have been clarified with the primary physician to ensure it was to continue as a current order for R5. RN-D further verified if staff were applying and assisting R5 with the oxygen, a prescriber order was required. The facility's Resident Records policy dated August 1, 2021, identified the resident record will contain orders or prescriptions for medications, treatments or therapies that the agency will be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	02040		

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02040	Continued From page 68 Based on interview and record review the licensee failed to provide hazard vulnerability assessment or safety risk, as required by MN Statute 144G.81, Subd.1 (a). 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), 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 October 19, 2021, between 10:20 a.m. and 11:00 a.m. an interview and record review was conducted with the licensed assisted living director in residence (LALDIR) on the facility hazard vulnerability assessment. Based on this record review, the licensee did not have a record or a policy on a hazard vulnerability assessment or safety risk for the property. An interview conducted with the LALDIR verified that they have not conducted a hazard vulnerability assessment or safety risk for the facility at this time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification	02240		

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02240	Continued From page 69 (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the	02240		

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02240	Continued From page 70 assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and information about how to make a complaint was provided to the residents and a written acknowledgement received for five of seven residents (R1, R2, R4, R5, R9) with records reviewed. 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 the potential to affect a large portion or all the residents). R1 R1 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current bill of rights, and a written acknowledgement of receipt. R2 R2 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current bill of rights, and a written acknowledgement of receipt. R4 R4 began receiving assisted living services on August 1, 2021. The resident's record lacked	02240		

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	30399	A. BUILDING: _____ B. WING _____	10/21/2021

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02240	Continued From page 71 evidence of the current bill of rights, and a written acknowledgement of receipt. R5 R5 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current bill of rights, and a written acknowledgement of receipt. R9 R9 began receiving assisted living services on August 1, 2021. The resident's record lacked evidence of the current bill of rights, and a written acknowledgement of receipt. On October 20, 2021, at 2:32 p.m. registered nurse (RN)-D stated she was unable to locate evidence of R1, R2, R4, R5, and R9's receipt of current bill of rights and indicated there was confusion as to who was responsible for what when updated forms and paperwork had been sent out July 2021, to all the residents. On October 21, 2021, at approximately 12:03 p.m. RN-C verified R1, R2, R4, R5, and R9's record lacked evidence of receiving the current bill of rights. The licensee's Resident Records policy dated August 1, 2021, identified the resident record was to include "documentation that the resident has received and reviewed the following the assisted living bill of rights and documentation that the agency staff has reviewed the bill of rights with the resident." No further information was provided. TIME PERIOD FOR CORRECTION:	02240		

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02240	Continued From page 72 Twenty-One (21) days	02240		
02310 SS=G	144G.91 Subd. 4 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 interview and document review, the licensee failed to provide care in accordance with accepted healthcare standards for one of one resident (R6) by completing a change of condition assessment and failed to create and implement interventions which resulted in serious injury. 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: R6's diagnoses included, but were not limited to, dementia (memory loss), osteoporosis (weakening of the bones), major depressive disorder, and history of head injury. R6's Service Plan Agreement signed on July 8, 2021, indicated services included medication administration, bathing, grooming, dressing,	02310		

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02310	Continued From page 73 ambulation, and toileting. R6's most recent nursing assessment dated July 15, 2021, completed by RN-D and was identified as a 90-day assessment. Resident Incident Reports for R6 indicated she had sustained falls on: - August 9, 2021, at 9:40 p.m. Fall Risk Assessment August 10, 2021, identified the resident as a risk for falls, but did not implement any interventions to prevent further falls. There was no incident investigation completed or documented and the appropriate medical professional was not notified as required. - August 12, 2021, at 9:45 p.m. Fall Risk Assessment dated August 13, 2021, identified the resident as a risk for falls, but did not implement any interventions to prevent further falls. There was no incident investigation completed or documented and the appropriate medical professional was not notified as required. - September 2, 2021, at 7:09 a.m. Fall Risk Assessment was not completed, no incident investigation was completed or documented, appropriate medical professional was not notified as required. - September 7, 2021, at 7:30 p.m. resident fell and was transferred the morning of September 8, 2021, for evaluation and sustained a fractured clavicle, fractured rib, and contusion of the right eye. There was no incident investigation completed or documented and the appropriate medical professional was not notified as required. A follow up progress note dated September 8, 2021, at 11:25 a.m. indicated R6 had been in pain and was unable to move her left arm, resulting in ambulance transportation to the emergency room for evaluation. Results of the evaluation was a fractured clavicle and broken rib, and R6 was to	02310		

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02310	Continued From page 74 wear a sling at all times and prescribed a pain patch and ice packs for comfort. R6's record lacked documentation of significant changes in R6's condition and actions taken in response to the needs of R6 on four additional occasions (September 14, September 20, September 25 and October 11). -September 14, 2021, at 10:56 a.m. a progress note by licensed practical nurse (LPN)-F indicated staff reported R6 making "suicidal actions by smothering her face into a pillow and wrapping her pull cord around her neck" the evening prior. Staff educated not to have her alone in her room until a plan could be implemented for her safety if the actions continued. -September 20, 2021, at 10:39 a.m. a progress note by RN-D indicated the resident was "unresponsive" and sent to the ER. R6 returned from the emergency room with no orders. RN-D indicated R6 has "medically declined" and hospice may be an option. -September 25, 2021, at 11:00 p.m. progress note late entry by RN-C indicated R6 was found in her apartment lying on her side with the air-conditioner's electrical cord wrapped around her neck attributing the actions to "apparent suicide attempt". R6 was evaluated in the emergency room and sent back to the facility. The note further indicated RN-C directed staff to remove any cords, sharp objects, and anything else that could be used as a weapon for self-harm, and staff were to "try to monitor the resident every half hour". R6 was admitted to hospice services on October	02310		

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02310	Continued From page 75 11, 2021. During an interview on October 20, 2021, at 1:25 pm, RN-D verified R6's record lacked incident investigations, fall assessments, safety interventions, and physician notification. She further stated, "we talked bout them but nothing was written down". The licensee's policy dated July 19, 2021, titled Reporting, Documenting, and Reviewing Incidents Involving Residents indicated The RN will complete an assessment of the resident in a timeframe that is reasonable following the incident; the RN will document in the resident's chart the details of any incident involving the resident and their assessment including the follow-up actions that were taken; the physician, resident representative, the Director of Health Services or designee will be notified of the incident and notifications will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a dignified dining experience for one of one resident (R4) observed during dining.	02350		

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02350	Continued From page 76 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included, but were not limited to, Alzheimer's disease and diabetes. R4's Service Plan Agreement signed September 21, 2021, indicated R4 received assistance with activities of daily living and medication administration. On October 19, 2021, at approximately 11:55 a.m. staff were observed to be seating and directing residents to take their place in the memory care dining room for lunch. R4 was observed to be sitting in a Broda wheelchair (tilt-in-space seating product) in the kitchenette area by himself with his beverages, napkin, and utensils next to him on the counter. On October 19, 2021, at approximately 11:57 a.m. activities assistant (AA)-H put a clothing protector on R4 and handed him a glass of thickened water from the counter. R4 grasped the glass and was observed to drink independently. On October 19, 2021, at approximately 12:08 p.m. licensed practical nurse (LPN)-F was observed to stand in kitchenette next to R4 and	02350		

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02350	Continued From page 77	02350		

feed him spoonfuls of pureed food. LPN-F would pick up the bowl of food from the counter, and give R4 bites of food. LPN-F stood the entire time assisting R4 with the meal. No other residents were near R4.

On October 19, 2021, at 12:30 p.m. LPN-F indicated R4 was fed in the kitchenette because the medication aide is assigned to assist R4 with the meal, and there wasn't a good spot in the dining room for R4 to sit. LPN-F then identified an area in the dining room that would accommodate R4, and indicated R4 could have sat at that table with others and still have staff assistance for a more enjoyable mealtime.

On October 19, 2021, at approximately 2:07 p.m. registered nurse (RN)-D stated R4 had always sat in the kitchenette for lunch. RN-D verified R4 was "kind of all by himself" there and had never thought of it, but confirmed it was not a dignified dining experience for R4 when staff stand to assist and he is not seated by others for the meal.

On October 20, 2021, at approximately 8:52 a.m. family member (FM)-G stated he was not aware R4 was assisted with meal in kitchenette away from others. FM-G indicated R4 would be happier sitting at a table with staff assistance, stating it would be a more "normal" and dignified dining experience.

A policy regarding dignity/respect of residents was requested, but not provided.

No further information provided.

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

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03000	Continued From page 78	03000		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	03000		

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03000	Continued From page 79	03000		

determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R6) with record reviewed.

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

The findings include:

R6's diagnoses included, but were not limited to, dementia (memory loss), osteoporosis (weakening of the bones), major depressive disorder, and history of head injury.

A Resident Incident Report dated September 7, 2021, at 7:30 p.m. identified R6 was found on the common living room floor with her wheelchair

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03000	Continued From page 80	03000		

folded next to her. The form further indicated initial injuries sustained from the fall was bruising and skin tear on her right eye. The registered nurse (RN-D) was notified. The incident investigation section was not completed.

A progress note dated September 8, 2021, indicated R6 was sent to the emergency room at 6:07 a.m. with complaints of pain, bruising, and inability to move her left arm. R6 returned to the facility with diagnoses of fractured clavicle (collar bone) and broken rib.

An After Visit Summary form dated September 8, 2021, indicated injuries of contusion face, abrasion left eyebrow, fractured left clavicle, fractured left rib, and separation acromioclavicular (joint at the top of the shoulder).

On October 20, 2021, at approximately 5:00 p.m. RN-D stated she did not report R6's incident to MAARC because she "thought" she knew what happened. She further stated the incident was unwitnessed with a serious injury but did not have an internal investigation available for review.

The licensee's Vulnerable Adult Reporting and Investigation Policy dated March 1, 2018, indicated agency staff is required to report to the MAARC when a client has sustained a physical injury which is not reasonably explained. Such physical injuries may include, but are not limited to, unexplained bruises, skin tears, lacerations, or fractures. Staff that observes an unexplained physical injury will immediately notify the DOHS (director of health services) or nursing in charge, who will conduct an internal investigation, to determine whether the injury is unexplained and whether a report to MAARC is required. If it is

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03000	Continued From page 81 unclear whether maltreatment occurred, the DOHS, nurse in charge, or ED will immediately begin investigating the incident. If within the 24 hours following the initial incident report and it is still unsure whether reportable maltreatment has occurred, an oral report to MAARC will be made. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	03090		

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03090	Continued From page 82 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 finding include: On October 18, 2021, at approximately 11:21 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On October 19, 2021, at 9:31 a.m. the licensed assisted living director in residence (LALDIR) stated the facility had done a remodel within the past year and had added a new board for licenses and notices at the main entrance. The LALDIR indicated the required notice must not had been put back up. The LALDIR verified the door utilized by the surveyors was considered the main door, and confirmed no posting was available related to the statutory language for electronic monitoring. The facility's 2.15 Electronic Monitoring policy dated August, 2021, noted signs were installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *10/19/21*
Time: 14:33:08
Report: 1028211044

Food and Beverage Establishment Inspection Report

Location:
Goldfinch Estates
850 Goldfinch St.
Fairmont, MN56031
Martin County, 46

Establishment Info:
ID #: N000004
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:
Mandy Farrow
Phone #:
ID #:

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

The following orders were issued during this inspection.

3-200B Food Characteristics:Receiving: temperature, condition

3-202.14A ** Priority 1 **

MN Rule 4626.0177A Discard unpasteurized egg products.

Unpasteurized egg products must be removed from the establishment. Begin only using pasteurized egg products as you are serving a highly susceptible population.

Comply By: 10/20/21

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

The blade of the stationary can opener must be cleaned to remove food residue.

Comply By: 10/20/21

2-100 Supervision

2-102.12AMN

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

Trevor Spooner passed a qualifying ServSafe CFPM course in July 2020, but did not submit his exam certificate to the State in time. Trevor must retake a CFPM course. Information on how to apply to the State was provided.

Comply By: 10/20/21

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Provide a handwashing poster at the handwashing sink in the memory care kitchen area.

Comply By: 10/20/21

Surface and Equipment Sanitizers

Lactic Acid/DDBSA: = 272ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Cream Cheese
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -3 Degrees Fahrenheit - Location: ikon Freezer - Ambient
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Corned Beef
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: -5 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

Type: Full
Date: *10/19/21*
Time: 14:33:08
Report: 1028211044
Goldfinch Estates

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028211044 of 10/19/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us