DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 24, 2022

Administrator
Prairie View
1010 East Elm Avenue
Hector, MN 55342

RE: Project Number(s) SL30230015

Dear Administrator:

On May 19, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 11, 2022, 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

April 4, 2022

Administrator
Prairie View
1010 East Elm Avenue
Hector, MN 55342

RE: Project Number(s) SL30230015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 11, 2022, 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 Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and 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), 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, no immediate fines are assessed.

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 by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. 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 resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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 of the correction order receipt date.

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

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

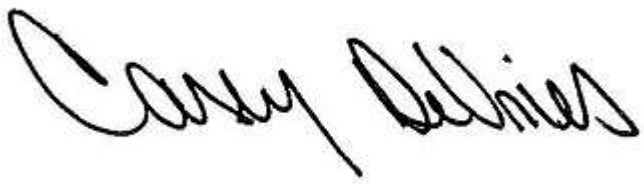
St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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 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.

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,



Casey DeVries, Supervisor
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State Evaluation Team
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P.O. Box 3879
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Telephone: 651-201-5917 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
	30230	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW	1010 EAST ELM AVENUE HECTOR, MN 55342

(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(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30230015 On, March 7, 2022, through March 11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 25 residents, 19 receiving services under the provider's 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.	
0 480 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: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 8, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of five residents (R2) 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: R2's record lacked an individualized abuse prevention plan to include all areas of vulnerability, as well as specific measures to minimize the risk of abuse.	0 630		

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0 630	Continued From page 3 The resident's undated Individual Abuse Prevention Plan (IAPP) identified vulnerabilities including an inability to identify potentially dangerous situations and a lack of community orientation skills with specific measures to minimize the risk of abuse. However, the plan failed to identify falls as a vulnerability. R2 had a contract dated July 29, 2021, signed by the resident's representative. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration. On March 9, 2022, at approximately 1:40 p.m., RN-A confirmed R2 had a history of falls, and was not identified as a vulnerability in the IAPP. The licensee's Maltreatment Prohibition policy dated August 1, 2022, noted an evaluation of each resident would be completed to determine areas of vulnerability and to develop an IAPP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650		

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0 650	Continued From page 4 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 650		

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0 650	Continued From page 5 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment on May 23, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's record contained a Performance Evaluation Form dated September 1, 2020. However, the record lacked any further annual performance evaluations. On March 11, 2021, at approximately 9:05 a.m., consultant registered nurse (CRN)-B confirmed the employee's record lacked a current performance evaluation. The licensee's Employee Recruitment, Selection, Hiring and Retention policy, dated April 19, 2021, noted performance reviews would be completed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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	0 680		

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0 680	Continued From page 6 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 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 have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 7 The findings include: On March 10, 2022, at approximately 12:35 p.m., the surveyor reviewed the emergency preparedness plan and Appendix Z with consultant registered nurse (CRN)-B. CRN-B confirmed the licensee lacked a customized emergency preparedness plan and appendix Z to include: - risk assessment to include care related emergencies an interruption to normal supply of essential resources and medical supplies; - arrangements/contracts to re-establish utility services; - identification of at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - to include a qualified person who is authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure to address alternate sources of energy to maintain safe/sanitary storage of provisions; - policy and procedure to address transportation; - policy and procedure to address identification of evacuation locations; - policy and procedure to address development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; and - develop a written communication plan to include: - names/contact information of residents' physicians and other facilities; - EP training and testing program.	0 680		

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0 680	Continued From page 8 In addition, the licensee failed to post the emergency disaster plan prominently as required. The licensee's Plan Introduction policy dated August 1, 2021, noted the plan must be located in multiple areas in the care center, and must be available for review by all staff, residents and families. The licensee's Emergency Preparedness - Disaster Plan policy dated August 1, 2021, noted the plan would include a hazard vulnerability assessment, communication plan, loss of services or supplies, evacuation, and training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 9 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 810		

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0 810	Continued From page 10 A record review and interview were conducted on March 8, 2022, between approximately 9:30 a.m. and 10:30 a.m. with Consultant RN (CRN)-B, Director of Maintenance (DM)-G, and Maintenance (M)-C on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, CRN-B stated that the facility fire safety and evacuation plans did not include provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, CRN-B stated that the facility fire safety and evacuation plans did not include provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, CRN-B stated that the licensee provides training on fire safety annually per company policy. Record review indicated that that the licensee had not conducted evacuation drills every other month as required with. During interview, CRN-B stated that the licensee had not conducted any evacuation drills since the new requirements went into effect on 8/01/21. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 11 (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing	0 900		

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0 900	Continued From page 12 contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of the contract. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of the contract as required. On March 10, 2022, at approximately 10:52 a.m., consultant registered nurse (CRN)-B and administrator (A)-C stated they were not sure if an unsigned copy of the contract had been provided to the Office of Ombudsman for Long-Term Care as required but would check with their representative from that office. A policy related to the assisted living contract was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and R2) 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 potential to affect a large portion or all of the residents). The findings include: R1 and R2's Assisted Living Contract dated July 27, 2021, and July 29, 2021, respectively noted the name and physical mailing address of the authorized agent but lacked the telephone number as required.	0 910		

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0 910	Continued From page 14 On March 10, 2022, at approximately 10:52 a.m., consultant registered nurse (CRN)-B confirmed the contract lacked the authorized agent's telephone number. A policy related to the content of the contract was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	0 970		

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0 970	Continued From page 15 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's assisted living contract included: - Page 14, section 2. Indemnification. "Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." - Page 14, section 3. Insurance. "Provider will maintain appropriate levels and types of insurance covering the building and its contents. Because Provider does not maintain insurance covering the contents of residents' Apartment Units or storage lockers, Resident is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Apartment Unit, as well as any injury to Resident or Resident's guests occurring within the Apartment Unit (this is usually called "renter's insurance"). Resident acknowledges and understands that the lack of such insurance coverage may result in personal loss to and/or liability of Resident." - Page 14-15, section 4. Liability. "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as a result of an equipment malfunction or hazardous conditions within the building not	0 970		

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0 970	Continued From page 16 caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of the Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises. Resident will not be liable to the Provider, or any other person claiming through or under Provider by right of subrogation or otherwise, for damage to the Apartment Unit or to Provider's premises from causes or risks normally covered by standard fire and extended coverage insurance, or which are actually covered by any other insurance. The parties to this Contract shall procure from their insurers a waiver of all rights of subrogation which one insurer under said policies might have as against another, said waiver to be in writing for the express benefit of the other." On March 10, 2022, at approximately 11:00 a.m., consultant registered nurse (CRN)-B confirmed the contract had the above language with a waiver. A policy related to contract content was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01620	Continued From page 17	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for two of two residents (R1 and R2) 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	01620		

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cause serious injury, impairment, or death), and was issued 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:

R1 and R2's records lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment.

R1
R1 had a contract dated July 27, 2021, signed by the resident's representative.

R1's Service Plan dated, 2021, indicated R1 received services that included staff assistance with blood glucose (BG) monitoring and medication administration.

R1's record included Evaluations dated September 24, 2021, and December 28, 2021, (95 days from the last date of the assessment, exceeding 90 calendar days).

R2
R2 had a contract dated July 29, 2021, signed by the resident's representative.

R2's Modification (identified as a modification to the service plan by RN-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration.

R2's record included Evaluations dated

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01620	Continued From page 19 November 12, 2021, and February 16, 2022, (96 days from the last date of the assessment, exceeding 90 calendar days). On March 9, 2022, at approximately 1:40 p.m., registered nurse (RN)-A stated she would check if there was a more recent reassessment, but no further information was provided. RN-A confirmed assessments should be completed no more than 90 days from the date of the last assessment. The licensee's Nursing Assessment policy dated August 1, 2021, noted the RN would complete the pre-admission assessment prior to the resident signing a contract with the care center, but lacked information on the frequency of the reassessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (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	01640		

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01640	Continued From page 20 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 ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of two residents (R2) 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: R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, lacked a signature or other authentication by the resident and by the facility, documenting agreement on the services to be provided. On March 9, 2022, at approximately 1:40 p.m., RN-A stated R2's modification lacked a signature	01640		

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01640	Continued From page 21 by the licensee or the resident's representative as required. RN-A stated she had received a verbal agreement but provided no documentation of such. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, noted the service plan and any revision must include a signature with the name, title and date the licensee's designee and a signature or other authentication by the resident or the resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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	01650		

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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 chapters.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2) 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:

R2's service plan lacked an accurate description of the services to be provided.

R2 had a contract dated July 29, 2021, signed by the resident's representative.

R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to

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01650	Continued From page 23 include assistance with activities of daily living and medication administration. In addition, the modification noted one person assist for ambulation, using a four wheeled walker and gait belt, with the wheelchair behind for safety. On March 10, 2022, at approximately 12:20 p.m., consultant registered nurse (CRN)-B confirmed R2 no longer ambulated, and that information should not have been on the service plan, as R2 currently transferred with a EZ stand (device used to assist from a seated to standing position or standing to seated), effective November 8, 2021. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, noted the service plan would include a description of the assisted living services to be provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include	01700		

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an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for two of two residents (R1 and R2) 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:

During the entrance conference on March 7, 2022, at approximately 10:50 a.m., RN-A stated

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the licensee provided medication management services to the licensee's residents.

R1 and R2's records lacked evidence the RN had conducted a medication assessment to include:
- identification of all medications the resident was known to be taking;
- indications for medications; and
- side effects.

R1
On March 8, 2022, at approximately 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1 in his apartment.

R1 had a contract dated July 27, 2021, signed by the resident's representative.

R1's Service Plan dated, September 9, 2021, indicated R1 received services that included staff assistance with blood glucose (BG) monitoring and assistance with medication administration.

R1's prescriber orders dated October 1, 2021, included three medications to control blood glucose levels and one pain medication.

R1's Evaluation dated December 28, 2021, noted "Registered nurse has completed a medication review of each of the resident's prescriptions, over-the-counter medications and supplements, as directed in rule" and was marked yes.

R1's March 2022 Medication Sheet listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given.

R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30230	A. BUILDING: _____ B. WING _____	03/11/2022

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PRAIRIE VIEW	1010 EAST ELM AVENUE HECTOR, MN 55342

(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
01700	Continued From page 26 R2 had a contract dated July 29, 2021, signed by the resident's representative. R2's prescriber orders dated January 26, 2022, included three pain medications, one medication to lower blood pressure and one anti-anxiety medication. R2's Evaluation dated February 16, 2022, noted "all medications the resident is known to be taking were reviewed with the resident and/or responsible party." However, the evaluation lacked the above required content. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration. R2's March 2022 Medication Sheet listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. On March 9, 2022, at approximately 1:40 p.m., RN-A verified R1 and R2's assessments lacked the above required content, and stated the same form was utilized for all residents. The licensee's Medication Management Services policy dated August 1, 2021, noted the RN would conduct an assessment to include identification and review of all medications the resident was known to be taking, indications for medications and side effects. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

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01700	Continued From page 27 days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 28 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R1 and R2) 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: During the entrance conference on March 7, 2022, at approximately 10:50 a.m., RN-A stated the licensee provided medication management services to the licensee's residents. R1 and R2's records lacked a medication management plan to include: - procedures for staff to notify a registered nurse or appropriate licensed health professional when a problem arises with medication management services.	01730		

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01730	Continued From page 29	01730		

R1
On March 8, 2022, at approximately 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1 in his apartment.

R1 had a contract dated July 27, 2021, signed by the resident's representative.

R1's Service Plan dated, September 9, 2021, indicated R1 received services that included staff assistance with blood glucose (BG) monitoring and assistance with medication administration.

R1's prescriber orders dated October 1, 2021, included three medications to control blood glucose levels and one pain medication.

R1's Evaluation dated December 28, 2021, noted "Registered nurse has completed a medication review of each of the resident's prescriptions, over-the-counter medications and supplements, as directed in rule" and was marked yes.

R1's March 2022 Medication Sheet listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given.

R2
R2 had a contract dated July 29, 2021, signed by the resident's representative.

R2's prescriber orders dated January 26, 2022, included three pain medications, one medication to lower blood pressure and one anti-anxiety medication.

R2's Evaluation dated February 16, 2022, noted "all medications the resident is known to be

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01730	Continued From page 30 taking were reviewed with the resident and/or responsible party." However, the evaluation lacked the above required content. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration. R2's March 2022 Medication Sheet listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. On March 9, 2022, at approximately 1:40 p.m., RN-A verified the medication management plans lacked information on when to notify the RN, and stated the same form was utilized for all residents. The licensee's Content, Development and Revision of the Service Plan dated August 1, 2021, noted the individual medication management plan would include procedures for staff to notify the RN when a problem arose with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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:	01750		

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01750	Continued From page 31 (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 record review, the licensee failed to ensure as needed (PRN) medications had parameters for administration for one of two residents (R2) 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: R2's record lacked specific written instructions regarding the administration of PRN medication ordered with a dosage range. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration.	01750		

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01750	Continued From page 32 R2's prescriber orders dated March 7, 2022, included Systane Ultra 1-2 drops four times per day. On March 9, 2022, at approximately 1:40 p.m., registered nurse (RN)-A verified the order had a range and lacked specific instructions when to administer one drop or two drops. The licensee's Requesting and Receiving Prescriptions policy dated August 1, 2021, noted the licensed nurse must include in the new order any written instructions for staff to follow when implementing the new order or prescription. The licensee's Content of Medication Prescriptions & Treatment or Therapy Orders policy dated August 1, 2021, noted a medication prescription must include the name and quantity of the drug prescribed, and the dosage. No further information was 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	01760		

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01760	Continued From page 33 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 as needed (PRN) medications had documentation of effectiveness after administration for one of two residents (R2) 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: R2's prescriber orders dated January 26, 2022, included morphine 5 milligrams (mg) every hour PRN for pain. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration. R2's March 2022 Medication Sheet identified the administration of the following: - March 3, 2022, March 4, 2022, and March 7, 2022, morphine administered with no documentation of the time administered or effectiveness.	01760		

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01760	Continued From page 34 On March 9, 2022, at approximately 1:40 p.m., registered nurse (RN)-A verified the PRN medications lacked the required documentation and stated staff are expected to document the time the medications are administered and a follow-up for the effectiveness of the medications. The licensee's Medication Management Services policy dated August 8, 2021, noted all staff would document PRN medication administration to include a follow up with the resident to determine the effectiveness of the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations for one of one resident (R1) with insulin and failed to properly secure narcotic medications for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 35 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: STORAGE ACCORDING TO MANUFACTURER'S RECOMMENDATIONS: R1's prefilled insulin pen was not stored according to manufacturer's recommendations. On March 8, 2022, at approximately 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1 in his apartment. R1 received Novolog FlexPen (insulin in a prefilled pen). The opened insulin pen was placed in the resident's refrigerator in his apartment after administration was completed. In addition, the refrigerator contained a box of unopened Novolog FlexPen medication containing four pens. ULP-E confirmed all insulin pens were stored in the refrigerator. The manufacturer's instructions for Novolog FlexPen dated November 2021, instructed to store unopened / unused pens in the refrigerator between 36 - 46 degrees Fahrenheit (F), and in use cartridges are to be stored at room temperature below 86 degrees F. On March 10, 2022, at approximately 12:20 p.m., consultant registered nurse (CRN)-B stated medications should be stored according to manufacturer's recommendations and verified refrigerator temperatures were not being logged for R1's insulin storage.	01880		

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01880	Continued From page 36 A policy related to insulin storage was requested but not provided. PROPERLY SECURING CONTROLLED SUBSTANCES: R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with medication administration. R2's prescriber's orders dated, January 12, 2022, indicated R2 was prescribed the following controlled substance: Norco 325/5 milligrams (mg) tablets. Order read to take Norco 325/5 mg by mouth (PO) twice a day; okay to crush and Norco 325/5 mg PO twice a day as needed (PRN). On March 9, 2022, at 11:10 a.m., the surveyor observed two medication cards of Norco 325/5 mg, 30 tablets each stored inside a locked cupboard in R2's room. The cards were located next to a locked metal box inside of the cupboard. The Norco was stored with R2's non-controlled medications. On March 8, 2022, at 11:40 a.m., RN-A confirmed Norco should have been stored behind a double lock. The licensee's Controlled Substances policy dated August 1, 2021, noted all controlled substances would be double locked at all times, in a separately locked compartment, permanently affixed to the physical plant or medication cart. No further information was provided.	01880		

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01880	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 date time sensitive medications with a date when opened for one of one resident (R1) with insulin. 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: During the entrance conference on March 7, 2022, at approximately 10:50 a.m., registered nurse (RN)-A stated the licensee provided medication management services to the licensee's residents.	01890		

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01890	Continued From page 38 On March 8, 2022, at approximately 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer insulin to R1 in his apartment. Additionally, the surveyor observed the medication storage in R1's locked cabinet in the presence of ULP-E, who confirmed the findings. R1's Tresiba FlexTouch insulin pen lacked a date to indicate when staff opened it, or when it would expire. The manufacturer's instructions for Tresiba dated March 2016, indicated Tresiba lasts 8 weeks without refrigeration once in use, if kept at room temperature. R1's Novolog FlexPen insulin pen lacked a date to indicate when staff opened it, or when it would expire. The manufacturer's instructions for Novolog FlexPen dated November 2021, instructed to discontinue use 28 days after starting to use the pen. A policy related to dating time sensitive medications was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	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	01940		

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01940	Continued From page 39 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 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1) 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	01940		

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01940	Continued From page 40	01940		

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:

During the entrance conference on March 7, 2022, at approximately 10:50 a.m., registered nurse (RN)-A stated the licensee provided treatment management services to the licensee's residents.

R1's records lacked a treatment management plan to include:
- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy management services.

In addition, R1's record lacked parameters for blood glucose (BG) results.

R1
R1 had a contract dated July 27, 2021, signed by the resident's representative.

R1's Service Plan dated, September 9, 2021, indicated R1 received services that included staff assistance with BG monitoring.

R1's physician orders dated September 30, 2021, indicated R1 required assistance with BG monitoring four times a day and as needed (PRN).

R1's assessment dated December 28, 2021, indicated R1 required assistance with BG monitoring to include documentation of the result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30230	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW	1010 EAST ELM AVENUE HECTOR, MN 55342

(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
01940	Continued From page 41 and the registered nurse would provide diabetes monitoring and management. R1's treatment orders related to diabetes dated, December 28, 2021, indicated R1 needed assistance with regular BG testing and monitoring from assisted living staff. The plan did not indicate specific BG parameters for R1. On March 8, 2022, at approximately 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E observe R1 obtain his BG reading, and document this prior to providing insulin administration. R1's Service Checkoff List dated March 2022, for Blood Sugar Monitoring task indicated, "look at Dexcom receiver screen at time blood sugar reading is due to be checked and write result on calendar in med book. If Dexcom receiver is not showing a number on the screen, then complete blood sugar check using glucometer. HE MAY ALSO HAVE HIS BLOOD SUGAR CHECKED WHENEVER HE ASKS, based on how he feels. CP will verbally report blood sugars above or below goal range to nurse." There was no BG range for staff to reference. On March 9, 2022, at approximately 2:35 p.m., RN-A stated she did not know R1's specific BG parameters and agreed the parameters should be obtained and added to R1's plan. On March 9, 2022, at approximately 1:40 p.m., RN-A verified the treatment management plan lacked information on when to notify the RN, and stated the same form was utilized for all residents. The licensee's Content, Development and	01940		

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01940	Continued From page 42 Revision of the Service Plan dated August 1, 2021, noted the individual treatment management plan would include procedures for staff to notify the RN when a problem arose with treatment management services and documentation of specific resident instructions related to the treatments or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 43 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 8, 2022, between approximately 12:00 p.m. and 12:30 p.m. with Consultant RN (CRN)-B, Director of Maintenance (DM)-G, and Maintenance (M)-C on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, CRN-B stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests;	02170		

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	30230	A. BUILDING: _____ B. WING _____	03/11/2022

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02170	Continued From page 44 (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation with the required content, for one of one resident (R2) who resided in the secured memory care unit, with record review.	02170		

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02170	Continued From page 45 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: The facility had an assisted living with dementia care license, effective August 1, 2021. R2's record lacked an assessment and activities plan to include: - physical abilities and limitations, and - adaptations necessary for the resident to participate. R2 had a contract dated July 29, 2021, signed by the resident's representative. R2's Modification (identified as a modification to the service plan by registered nurse (RN)-A) dated February 28, 2022, noted services to include assistance with activities of daily living and medication administration. In addition, the modification instructed staff to engage resident in activities throughout the day, either one-on-one or in a group setting. On March 10, 2022, at approximately 10:52 a.m., the surveyor observed consultant registered nurse (CRN)-B demonstrate the activities information using the licensee's electronic computer system, which included R2's activities assessment and plan. CRN-B stated she was not	02170		

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02170	Continued From page 46 able to print the documents, but indicated it was located under the Social History section, dated September 21, 2021. CRN-B confirmed the record lacked the above required content. The licensee's Dementia Care policy dated August 1, 2021, noted an assessment of each resident would be completed by the RN, to include physical abilities and limitations and adaptations necessary for the resident to participate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content with records reviewed. This practice resulted in a level one violation (a	02260		

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02260	Continued From page 47 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, dated August 1, 2021. During the entrance conference on March 11, 2022, at approximately 10:50 a.m., registered nurse (RN)-A verified the licensee had a locked dementia unit. The surveyor requested a copy of the dementia training disclosure. The licensee's Notice of Dementia Training for Assisted Living with Dementia Care dated August 1, 2021, noted the licensed assisted living director (LALD) would receive at least two hours of training annually, short of the required 10 hours. On March 9, 2022, at approximately 1:34 p.m., consultant RN (CRN)-B verified the dementia disclosure did not note the correct annual training for the LALD. The licensee's Dementia Care policy dated revised August 1, 2021, lacked information on the dementia disclosure content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *03/08/22*
Time: 13:10:01
Report: 1028221045

Food and Beverage Establishment Inspection Report

Location:
Prairie View
1010 East Elm Avenue
Hector, MN55342
Renville County, 65

Establishment Info:
ID #: 0039289
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3208482093
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

The stove must be repaired or replaced such that grease drains into the grease trap and not onto the floor.

Comply By: 03/14/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Hot Water: = at 190 Degrees Fahrenheit
Location: Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Display Cooler
Temperature: 39 Degrees Fahrenheit - Location: Display Cooler - Ambient
Violation Issued: No

Type: Full
Date: *03/08/22*
Time: 13:10:01
Report: 1028221045
Prairie View

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD's Inspection.

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 1028221045 of 03/08/22.

Certified Food Protection Manager Candy Markgraf

Certification Number: FM107775 Expires: 08/31/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Candy Markgraf
Food Service Supervisor

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