DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronically Delivered

April 14, 2022

Administrator
Arbor Park Living Center LLC
2921 6th Avenue North
Moorhead, MN 56560

RE: Conditional License Number 404596
Health Facility Identification Number (HFID) 30361
Project Numbers SL30361015 & HL30361002C

Dear Administrator:

On April 6, 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 January 19 and 20, 2022. The April 6, 2022, follow-up evaluation determined your agency had corrected some, but not all, of the state licensing orders. **Based on the improvements, the conditions on the license will be removed, effective date of this letter; however, non-compliance remains.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 19 and 20, 2022, found not corrected at the time of the April 6, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1700-Provision Of Medication Management Services-144g.71 Subd. 2
1770-Documentation Of Medication Setup-144g.71 Subd. 9
1890-Prescription Drugs-144g.71 Subd. 20
2310-Appropriate Care And Services-144g.91 Subd. 4 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on April 6, 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.

Also, at the time of this follow-up evaluation completed on April 6, 2022, we identified the following violation(s):

1970-Treatment And Therapy Orders-144g.72 Subd. 6
3070-Form Requirements-144.6502, Subd. 6

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

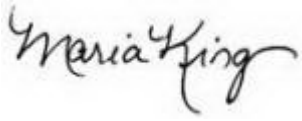
correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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, Supervisor, at jodi.johnson@state.mn.us, or 507-696-2437.

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,



Maria King, RN
Interim Division Director

Minnesota Department of Health
Health Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	R 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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 # SL30361015-2 On April 4, 2022, through April 6, 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 September 30, 2021, and January 20, 2022. At the time of the survey, there were 41 residents: 41 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. On April 5, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of G, isolated level three.	{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 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 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 144A.474 subd. 11 (b) (1) (2).	
{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}		
{0 810} 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	{0 810}		

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{0 810}	Continued From page 2 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}		
{01650} SS=C	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:	{01650}		

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{01650}	Continued From page 3 (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 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for five of five residents (R1, R3, R4, R7, R23) with records reviewed. This had the potential to affect all 41 residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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: R1 R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic	{01650}		

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{01650}	Continued From page 4 obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. On April 5, 2022, at 11:10 a.m., unlicensed personnel (ULP)-Y was observed to conduct a blood glucose monitoring check on R1. R1's service plan dated January 21, 2022, lacked the following required content: - a contingency plan that included the action to be taken if the scheduled services cannot be provided. R3 R3's diagnoses included, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's service plan dated March 21, 2022, indicated R3 received services which included medication administration, Prevalon boots (pressure relieving boots), feeding tube management, laundry, housekeeping and assistance with grooming, bathing, and toileting. R3's above noted service plan lacked the following content: - a contingency plan that included the action to be taken if the scheduled services cannot be provided. R4 R4's diagnoses included anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4 service plan dated March 25, 2022, indicated	{01650}		

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{01650}	Continued From page 5 R4 received services which include medication management, laundry, and housekeeping. R4's above noted service plan lacked the following content: - a contingency plan that included the action to be taken if the scheduled services cannot be provided. R7 R7's diagnoses included adjustment disorder with depressed mood, chronic pain syndrome, insomnia and neuropathy (disease of the nerves causing numbness and weakness). R7's service plan dated January 31, 2022, indicated R7 received services which included medication setup, laundry and housekeeping. R7's above noted service plan lacked the following content: - a contingency plan that included the action to be taken if the scheduled services cannot be provided. R23 R23's diagnoses included dementia, hypertension (HTN), chronic ischemic heart disease (where the heart is not getting enough blood and oxygen), congestive heart failure (a chronic condition in which the heart doesn't pump blood), bradycardia (slow heart rate), restlessness, agitation and a history of falls. R23's service plan dated April 1, 2022, indicated R23 received medication and oxygen management, assistance with dressing, grooming, bathing, transferring, mobility, positioning, toileting, laundry, and housekeeping.	{01650}		

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{01650}	Continued From page 6 R23's above noted service plan lacked the following content: - frequency of all services provided, and - a contingency plan that included the action to be taken if the scheduled services cannot be provided. On April 5, 2022, at 4:31 p.m., registered nurse (RN)-W and licensed assisted living director (LALD)-A confirmed R1, R3, R4, R7 and R23's service plans were incomplete and did not include the above noted content. LALD-A stated this was a template service plan that was used for all residents. The licensee's Service Plan policy dated December 10, 2021, indicated the service plan would include: - the frequency of each service to be provided based on the most recent assessment and resident preferences, and - a contingency plan that would include actions the licensee would take if scheduled services could not be provided. No further information was provided.	{01650}		
{01700} SS=D	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.	{01700}		

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{01700}	Continued From page 7 This assessment must be conducted face-to-face with the resident. The assessment must include 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 observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) to determine what medication management services would be provided included all required content for one of one resident (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).	{01700}		

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{01700}	Continued From page 8 The findings include: R23's diagnoses included dementia, hypertension (HTN), chronic ischemic heart disease (where the heart is not getting enough blood and oxygen), congestive heart failure (a chronic condition in which the heart doesn't pump blood), bradycardia (slow heart rate), restlessness, agitation and a history of falls. R23's service plan dated April 1, 2022, indicated R23 received medication management services. R23's prescriber orders dated February 17, 2022, and hospice orders April 1, 2022, included two antihypertensives, one laxative, one medication to treat insomnia, one medication to treat severe pain and one medication to treat mild pain, one medication to treat depression, and one medication to treat anxiety/restlessness. On March 4, 2022, at 2:41 p.m. the surveyor observed unlicensed personnel (ULP)-G administer R23's oral medications. R23's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include a review of the side effects and contraindications for the following medications: morphine sulfate 2 milligrams (mg) (pain reliever), citalopram 10 mg (anti-depressant), Lasix 20 mg (a medication to treat edema), losartan potassium 100 mg (medication to treat HTN), senna syrup 8.8 mg (a medication to treat constipation), trazadone 50 mg (a medication to treat depression and insomnia), acetaminophen 650 mg, and Seroquel 25 mg (a medication to treat mood disorders/insomnia).	{01700}		

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{01700}	Continued From page 9 On April 5, 2022, at 4:40 p.m., RN-W confirmed R23's medication management assessment did not include all the required content as noted above. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated December 13, 2021, indicted the assessment must include an identification and review of all medications to include indications for medication, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided.	{01700}		
{01770} SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document all required content for medication setup for two of two residents (R7, R21) receiving medication set up services 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	{01770}		

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{01770}	Continued From page 10 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R7 R7's diagnoses included adjustment disorder with depressed mood, chronic pain syndrome, insomnia and neuropathy (disease of the nerves causing numbness and weakness). R7's Individualized Medication Management Plan and service plan dated January 11, 2022, and January 31, 2022, respectively indicated R7 received twice monthly medication setup by a licensed nurse. R7's prescriber orders dated April 23, 2021, May 21, 2021, August 27, 2021, September 3, 2021, September 13, 2021, October 14, 2021, November 4, 2021, November 9, 2021, November 15, 2021, and January 7, 2022, included the following orders: amlodipine besylate 25 milligrams (mg) one time a day for blood pressure; atorvastatin 40 mg once a day for history of stroke; aspirin 81 mg once a day for history of stroke; calcium 600 mg twice a day for osteopenia; finasteride 5 mg once a day for enlarged prostate; gabapentin 300 mg three times a day for neuropathy; acetaminophen 1000 mg three times per day for pain; levothyroxine 125 micrograms (mcg) daily for hypothyroidism; omeprazole 20 mg twice daily for gastric reflux disease; senna plus 8.6-50 mg daily for constipation; Toprol XL 100 mg daily for high blood pressure; and vitamin D3 2000 units by mouth once a day for osteopenia. R7's Progress Notes dated April 1, 2022, written	{01770}		

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{01770}	Continued From page 11	{01770}		

by registered nurse (RN)-X noted RN-X had "filled resident's mediplanner [a plastic medication box with designated compartments for days and times]".

R7's Progress Noted dated April 17, 2022, written by RN-W noted "This nurse set up residents [sic] medications as ordered for them to self administer".

R7's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, and route of administration.

On April 5, 2021, at 4:18 p.m. RN-W stated medication setup was documented in the resident's progress notes. RN-W confirmed R7's medication record including the progress notes did not include documentation of medication setup as required.

R21
R21's diagnoses included vascular dementia with behavioral disturbance and a cerebrovascular accident (CVA-stroke).

On April 4, 2022, at 1:14 p.m. a tour of the facility was conducted with RN-W, including a review of the locked medication cabinet in Aspen. RN-W observed and confirmed there were two (2) seven-day medication planners labeled with R21's name located beside and under R21's medication bin. One medication planner was labeled for 6:00 p.m. and 8:00 p.m. and contained six blue and white capsules in the compartments marked for 6:00 p.m., for Monday, Tuesday and Thursday; and contained four (4) tablets (various sizes and colors) setup in compartments marked

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

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{01770}	Continued From page 12	{01770}		

for Tuesday, Thursday, and Friday. The second medication planner was labeled for 8:00 a.m., 12 p.m., 2:00 p.m., and 4:00 p.m. with a three (3) medications setup in the 12:00 p.m. compartments for each day of the week; one (1) tablet setup in the 2:00 p.m. compartment for each day of the week; and three tablets setup in the 4:00 p.m., compartment for Sunday, Monday, Tuesday, and Saturday. The request was made to RN-W and RN-X for the documentation of the above noted medications, which had been setup for R21.

R21's service plan dated March 31, 2022, indicated the resident received medication management services to include medication administration.

R21's prescriber orders dated November 17, 2021, and December 15, 2021, included amlodipine 10 mg one time a day for blood pressure; aspirin 81 mg one time a day for stroke prevention; atorvastatin calcium 80 mg in the evening to treat high cholesterol; gabapentin 100 mg three times a day for nerve pain; calcium acetate 667 mg take three capsules three times a day; Depakote 125 mg take 500 mg in the morning and 750 mg in the evening for encephalopathy (a brain disease that alters brain function); famotidine 10 mg once daily for acid reflux; metoprolol succinate ER 200 mg one time daily for blood pressure; mirtazapine 15 mg every night at bedtime for sleep; olanzapine 5 mg three times daily an antipsychotic medication; ticagrelor 90 mg twice a day a blood thinner; and vitamin D3 1000 units daily a supplement.

R21's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the

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{01770}	Continued From page 13 medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup at the time of setup. On April 4, 2022, at 2:30 p.m. RN-W and RN-X stated they were unable to find documentation for R21's medications that had been setup in the medication planners noted above. The licensee's Medication Management - Administration and Setup policy dated December 13, 2021, noted the licensed nurse would correctly and accurately document any medication setup provided. No further information was provided.	{01770}		
{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 maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two residents (R10, R20) with records reviewed. This practice resulted in a level two violation (a	{01890}		

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{01890}	Continued From page 14 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: On April 4, 2022, at 1:14 p.m., a tour of the facility was conducted with registered nurse (RN)-W, including a review of the locked medication cabinets in Aspen. The following was observed and confirmed with RN-W. R10 R10's Lantus 100 units/milliliter insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. In addition, the insulin pen lacked the original prescription label. R20 R20's Ventolin HFA 90 microgram (bronchodilator) inhaler lacked a label to indicate when the inhaler had been opened and when the inhaler would expire. In addition, the inhaler lacked the original prescription label. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Ventolin inhalers dated January 2022, directed to discard the inhaler 12 months after removal from the foil pouch.	{01890}		

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{01890}	Continued From page 15 On April 4, 2022, at 1:20 p.m., RN-W confirmed all medications should have original labels and time sensitive medications should be dated after opening with an open and expiration date. The licensee's Medication Storage policy dated December 13, 2021, prescription drugs must be kept in their original container in which they were dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided.	{01890}		
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 observation, interview and record review, the licensee failed to ensure there were current treatment and therapy orders that included the frequency, duration, and other required information needed for one of one resident (R23) receiving oxygen with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970		

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01970	Continued From page 16	01970		

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:

R23's diagnoses included dementia, hypertension (HTN), chronic ischemic heart disease (where the heart is not getting enough blood and oxygen), congestive heart failure (a chronic condition in which the heart doesn't pump blood), bradycardia (slow heart rate), restlessness, agitation and a history of falls.

R23's record lacked an order for oxygen.

R23's service plan dated April 1, 2022, indicated R23 had oxygen management services.

On April 4, 2022, at 2:50 p.m., two oxygen cylinders and an oxygen concentrator were observed by the surveyor in R23's room.

On April 4, 2022, at 3:00 p.m., unlicensed personnel (ULP)-G stated oxygen was new for R23 after she started on hospice on April 1, 2022. ULP-G verified, R23's electronic medication and treatment record lacked instructions for oxygen use.

On April 4, 2022, at 3:17 p.m. registered nurse (RN)-W verified R23 had oxygen cylinders and a concentrator in R23's room and was unsure when the oxygen was delivered.

On April 5, 2022, at 4:37 p.m. RN-W confirmed

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01970	Continued From page 17 R23's record lacked orders and parameters for oxygen. The license's Medication and Treatment policy dated December 13, 2021, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
{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 observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards of one of one resident (R23) with bedrails who lacked a bed rail assessment and an explanation of risks and benefits of the use of bed rails. This resulted in an immediate order on April 5, 2022, at 2:03 p.m. In addition, the licensee failed to ensure the safe storage of oxygen for one of one resident (R23) with records reviewed. 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,	{02310}		

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{02310}	Continued From page 18 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: BEDRAILS R23's diagnoses included dementia, hypertension (HTN), chronic ischemic heart disease, congestive heart failure, restlessness, agitation, and had a history of falls. R23's Service Plan dated May 1, 2022, indicated R23 received services which included medication administration, housekeeping, laundry, assistance with bathing, dressing, grooming, toileting, transferring, and mobility. R23's Individual Abuse Prevention Plan Assessment dated April 1, 2022, indicated as a vulnerability, R23 utilized bed rails. R23's record lacked evidence a comprehensive side rail assessment had been completed and an explanation of the risks and benefits of the use of the side rail had been provided to the resident or resident's representative. On April 4, 2022, at 2:38 p.m. R23 was observed in her hospital bed with bilateral side rails in an upright position. On April 5, 2022, at 9:08 a.m. registered nurse (RN)-W confirmed R23's side rail assessment had not been assessed for safety, and the licensee did not provide education to the resident	{02310}		

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{02310}	Continued From page 19	{02310}		

or the resident's representative regarding the risks and benefits of having the side rails on R23's bed. RN-W further stated R23 recently was admitted to hospice on April 1, 2022, and hospice had ordered the hospital bed for R23. RN-W further stated she thought hospice completed the side rail assessment since hospice ordered the hospital bed. RN-W confirmed she conducted a side rail assessment on April 4, 2022, after the surveyors entered the facility and requested the documentation of a side rail assessment for R23. RN-W further verified she had not completed measurements of the side rails to ensure the side rails met the FDA recommended zone dimensions.

The licensee's Side rails policy dated December 13, 2021, indicated when side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The policy further indicated the side rail would be considered to be "safe" by meeting the following requirements:
-the side rails were used consistent with the manufacturer's directions;
-the side rails were installed securely and maintained in good operating condition and not "wobbly"; and
-the side rail design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment, which meant side rail zones 1,2, and 3 must not exceed 4.75".

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.

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{02310}	Continued From page 20 The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." TIME PERIOD FOR CORRECTION: Immediate The immediacy was removed as confirmed by documentation review and by the evaluation supervisor on April 5, 2022, at 3:55 p.m.; however, noncompliance remains at a scope and severity of level three, isolated (G). OXYGEN STORAGE R23's Service Plan dated May 1, 2022, indicated R23 received services which included medication administration, oxygen management, housekeeping, laundry, assistance with bathing, dressing, grooming, toileting, transferring, and mobility. On April 4, 2022, at 2:50 p.m. an oxygen cylinder was observed in R23's room laying on the floor on its side. Unlicensed personnel (ULP)-G verified R23 had two oxygen cylinders in her room, one oxygen cylinder was securely stored in	{02310}		

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{02310}	Continued From page 21 a caddy, and the other oxygen cylinder was laying on its side directly on the floor. On April 4, 2022, at 3:17 p.m. RN-W verified R23 had an oxygen cylinder laying on its side on the floor in R23's room. RN-W confirmed oxygen cylinders should be in an upright position, securely stored in a holder. The licensee's Oxygen and Oxygen Storage policy dated February 1, 2022, indicated oxygen cylinders must remain upright at all times and should never be tipped on its side. No further information was provided.	{02310}		
03070 SS=D	144.6502, Subd. 6 Form Requirements Subd. 6.Form requirements. (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain consent for electronic monitoring for one of one resident (R23) who had an electronic monitor device in place. 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	03070		

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03070	Continued From page 22 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R23's diagnoses included dementia, hypertension (HTN), chronic ischemic heart disease (where the heart is not getting enough blood and oxygen), congestive heart failure (a chronic condition in which the heart doesn't pump blood), bradycardia (slow heart rate), restlessness, agitation and a history of falls. On April 4, 2022, at 1:35 p.m. during the tour of the dementia care secured unit in building two, the surveyor observed a small electronic video and audio monitor device sitting on the counter in the nurse's station. Immediately following the above observation, registered nurse (RN)-W confirmed R23's family had wanted the electronic monitor device placed. RN-W confirmed the monitor had live feed and audio capability, but could not record. RN-W verified the live feed and audio could not be accessed on any other electronic device other than the monitor. The surveyor requested a copy of R23's signed consent for the use of an electronic monitoring device. R23's record lacked a consent for the electronic monitoring device that was placed in R23's room. On April 5, 2022, at 9:08 a.m. RN-W confirmed R23's record did not have a signed consent for the use of an electronic monitoring device at the time the surveyor requested a copy on April 4, 2022.	03070		

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03070	Continued From page 23 On April 5, 2022, at 4:49 p.m. licensed assisted living director (LALD)-A confirmed R23 had the electronic monitoring device since she was admitted on July 7, 2020. LALD-A confirmed the licensee did not have a written consent signed by R23 or her representative to place the electronic monitoring device in R23's room prior to April 4, 2022, after the surveyor requested the document. The licensee's Electronic Monitoring policy dated December 20, 2021, indicated for the use of electronic monitoring, the licensee requires all residents consent as outlined in 144.6502 Subd 3. The consent must be provided on the form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03070		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE EXTENSION AND SURVEY RESULTS

Electronically Delivered
February 18, 2022

Administrator
Arbor Park Living Center LLC
2921 6th Avenue North
Moorhead, MN 56560

RE: Conditional License Number 404596
Health Facility Identification Number (HFID) 30361
Project Number(s) SL30361015 & HL30361002C

Dear Administrator:

On January 19 and 20, 2022, the Minnesota Department of Health conducted a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 30, 2021. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the September 30, 2021 evaluation.

In addition, on January 19, 2022, this Department's State Rapid Response Team conducted an initial complaint evaluation of complaint HL30361002C and licensing correction order 0510 was issued.

As a result, the current Conditional License will be extended by an additional 60 days. This extension is due to expire on **April 19, 2022.**

All conditions noted in the Conditional Order effective on December 2, 2021, will remain in effect through the extended conditional license period.

The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Home Instead Senior Care and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-696-2437 with questions about reports.

Additionally, Arbor Park Living Center LLC will be required to have **a minimum of 16 hours of on-site consulting time each week** during the conditional license period pursuant to Minn. Stat. § 144G.20, Subd. 2 (a)(6).

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 30, 2021, found not corrected at the time of the January 20, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1. - $500.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b)
0510-Infection Control Program-144g.41 Subd. 3 - $3,000.00
0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0900-Contract Required-144g.50 Subdivision 1
0950-Designation Of Representative-144.50 Subd. 3
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2
1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4
1700-Provision Of Medication Management Services-144g.71 Subd. 2
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1770-Documentation Of Medication Setup-144g.71 Subd. 9
1820-Prescriptions-144g.71 Subd. 13
1880-Storage Of Medications-144g.71 Subd. 19 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5
2140-Supervising Staff Training-144g.83 Subd. 3 - $500.00
2170-Services For Residents With Dementia-144g.84 - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4
3000-Timing Of Report-626.557 Subd. 3

The details of the violations noted at the time of this follow-up evaluation completed on January 20, 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.

Also, at the time of this follow-up evaluation completed on January 20, 2022, we identified the following violation(s):

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)
0920-Contract Information-144g.50 Subd. 2
1420-Delegation Of Assisted Living Services-144g.62 Subd. 2
1650-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4
2070-Awake Staff Requirement-144g.81 Subd. 4 - $3000.00

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $8,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 507-696-2437.

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,

Maria King, RN
Interim Division Director

Minnesota Department of Health
Health Regulation Division **HHH**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	R 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	**2921 6TH AVENUE NORTH MOORHEAD, MN 56560**

(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 # SL 30361015-1 On January 19, through 20, 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 Septmber 30, 2021. At the time of the survey, there were 41 active residents receiving services under the Assisted Living Facility with Dementia Care license. As a result of the revisit, the following orders were reissued and issued. On January 20, 2022, the immediacy of correction order 2070 was removed, however non-compliance remains at a scope and level of D. REVISED: Correction order 2310 was written as an immediate order at a level G on January 20, 2022; however, the licensee provided additional	{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.	

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{0 000}	Continued From page 1 information and the immediate order was rescinded. On January 19, 2022, the Minnesota Department of Health initiated an investigation of complaint HL30361002C. The following correction order is issued for HL30361002C, tag identification 0510.	{0 000}		
{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 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	{0 250}		

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{0 250}	Continued From page 2 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; (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 ensure the management officials who were in charge of the day-to-day operations, and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This has 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	{0 250}		

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{0 250}	Continued From page 3 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 January 19, 2022, at 9:00 a.m. controller officer (CO)-M stated a plan of correction had been started; however, it was not complete. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.41, Subd 3. The licensee failed to follow guidance related to COVID-19. Refer to licensing order at Statute 144G.42, Subd 6. The licensee failed to timely report to Minnesota Adult Abuse Reporting Center (MAARC). In addition, the licensee failed to implement individual abuse prevention plans for all residents. Refer to licensing order at Statute 144G.42, Subd 9. The licensee failed to implement a tuberculosis (TB) prevention and control program. Refer to licensing order at Statute 144G.50, Subd 1 and Subd. 2. The licensee failed to develop, implement, and provide a contract containing all required content to all residents. Refer to licensing order at Statute 144G.50, Subd 3. The licensee failed to ensure all residents were provided the opportunity to designate a	{0 250}		

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{0 250}	Continued From page 4 representative, as required. Refer to licensing order at Statute 144G.62, Subd. 2. The licensee failed to ensure staff were trained and competency tested for delegated tasks. In addition, written instructions were available for delegated tasks. Refer to licensing order at Statute 144G.70, Subd 2. The licensee failed to ensure the registered nurse (RN) completed assessments of all residents at the frequency required and using the Uniform Assessment Tool, as required. Refer to licensing order at Statute 144G.70, Subd 4. The licensee failed to develop and implement a service plan for all residents. Refer to licensing order at Statute 144G.71, Subd 2. The licensee failed to ensure the RN completed face-to-face medication management assessments for all residents receiving medication management services. Refer to licensing order at Statute 144G.71, Subd 5. The licensee failed to ensure each resident receiving medication management services had an individualized medication management plan containing all required content. Refer to licensing order at Statute 144G.71, Subd 8. The licensee failed to ensure the medication administration process was followed. Refer to licensing order at Statute 144G.71, Subd 9. The licensee failed to ensure R7's documentation of medication setup included all required content. Refer to licensing order at Statue 144G.71, Subd	{0 250}		

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{0 250}	Continued From page 5 13. The licensee failed to ensure R3's record included orders for tube feeding. Refer to licensing order at Statute 144G.71, Subd 19. The licensee failed to ensure medications were stored according to manufacturer's instructions. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to ensure time sensitive medications were dated when opened and with expiration. In addition, the licensee failed to ensure all medications beared original prescription labels. Refer to licensing order at Statute 144G.72, Subd 3. The licensee failed to develop and maintain an individualized therapy management plan for all residents receiving treatments and/or therapies. Refer to licensing order at Statute 144G.72, Subd 5. The licensee failed to ensure documentation of all treatment and/or therapy services provided to residents. Refer to licensing order at Statute 144G81, Subd. 4. The licensee failed to ensure the facility was staffed 24 hours a day, seven days a week in the key pad secured unit (Building 2). Refer to licensing order at Statute 144G.83, Subd 3. The licensee failed to appoint a dementia trainer who met all requirements. Refer to licensing order at Statute 144G.84. The licensee failed to evaluate, develop, and implement an activity plan for all residents. Refer to licensing order at Statute 144G.91, Subd 4. The licensee failed to ensure R19 had been	{0 250}		

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{0 250}	Continued From page 6 assessed for appropriateness and safety in the use of a sit to stand lift for transferring. Refer to licensing order at Statute 626.557, Subd 3. The licensee failed to timely report to Minnesota Adult Abuse Reporting Center (MAARC). 26 correction orders were issued/reissued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.10 to 144G.95. No further information was provided.	{0 250}		
{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:	{0 480}		

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{0 480}	Continued From page 7 No further action required.	{0 480}		
{0 510} SS=I	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 document review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect all forty-one (41) residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 510}		

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{0 510}	Continued From page 8 PERSONAL PROTECTIVE EQUIPMENT (PPE) USE The 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 Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated December 7, 2021, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear eye protection in communities with high community transmission levels. On January 19, 2022, at approximately 9:50 a.m., dietary staff member (DS)-S was observed in the dining room area by the coffee machine with her eye protection (goggles) resting on the top of her head. Once DS-S saw the surveyor, she quickly placed the goggles over her eyes. Immediately following this observation, operations manager (OM)-P confirmed dietary staff should always be wearing a medical grade mask and eye protection. On January 19, 2022, at 12:20 p.m. unlicensed personal (ULP)-N stated staff should wear masks and eye protection at all times. ULP-N stated residents were tested if they wanted to or if they had a potential exposure. On January 19, 2022, at 12:36 p.m an	{0 510}		

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{0 510}	Continued From page 9	{0 510}		

unidentified facility office staff and several other individuals were observed in close contact in the main entrance common area with no masks on having a conversation.

On January 19, 2022, at 1:35 p.m. director of operations (DO)-P was observed talking to R10 (resident who was also identified as a dietary department employee.) R10 was observed to be within three feet of DO-P talking with no mask or eye shield on. As the surveyor approached, R10 left the area. DO-P was observed to pull a mask down when he entered his office, and stated he thought the facility was testing residents who had contact with positive staff, but was not sure. DO-P stated he expected all staff to wear a mask as all times in the facility unless they were alone in their office, then pulled his mask up over his face. DO-P confirmed R10 was an employee.

On January 19, 2022, at approximately 4:00 p.m. ULP-Q was observed in the resident care area visiting with two residents at the dining room table with her medical grade mask resting below her nose.

On January 19, 2022, at approximately 4:05 p.m. ULP-J was observed in the resident care area with his medical grade mask under his nose and eye goggles resting on top of his head.

On January 20, 2022, at approximately 6:00 a.m. ULP-E was observed assisting a resident outside of the medication room with their coat. ULP- E wore a medical grade mask, but no eye protection.

On January 20, 2022, at approximately 3:58 p.m. licensed assisted living director (LALD)-A and consulting registered nurse (RN)-V confirmed it

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{0 510}	Continued From page 10	{0 510}		

was the licensee's expectations that staff follow the current Minnesota Department of Health (MDH) and Center for Disease Control and Prevention (CDC) guidelines with regards to COVID-19 response.

On January 20, 2022, at approximately 4:00 p.m. LALD-A and consulting RN-V confirmed staff should be wearing appropriate eye protection and a medical grade mask when in resident care areas. LALD-A verified their current transmission level was high.

The licensee's policy and procedure titled "COVID-19 - Policy 2022" Section 1. indicated employees were required to wear personal protective equipment (PPE) including face masks and safety goggles during their shift. The policy failed to include information about PPE use for residents and visitors when in common areas.

The CDC Types of Masks and Respirators dated January 14, 2022, indicated masks should fit snugly over your nose, mouth, and chin.

The licensee's COVID-19 policy, undated, noted employees are required to wear protective face masks and safety goggles during their shift.

COVID-19 OUTBREAK TESTING

The Minnesota Department of Health Guidance, titled "COVID-19 Testing Guidance for Assisted Living Facilities", dated October 14, 2021, indicated facility-wide approach to COVID-19 testing should be considered if all potential

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{0 510}	Continued From page 11	{0 510}		

contacts cannot be identified, or if a facility does not have the expertise, resources, or ability to identify all close contacts, the facility should instead investigate the outbreak using a broad facility wide level. The guidance instructed facilities to perform testing for all residents and healthcare providers regardless of vaccination status, immediately and, if negative, again five to seven days later.

On January 19, 2022, at 10:20 a.m. during an entrance conference with DO-P, LALD-A, and RN-O stated they had no known COVID-19 positive residents in the facility, but currently had five COVID-19 positive staff in the dietary department. LALD-A stated residents were tested if they had a potential exposure, and further indicated no facility wide testing of the residents had been completed for the current outbreak or prior to that. LALD-A indicated they were beginning facility wide testing now. LALD-A stated RN-O was overseeing the infection control program briefly, but due to RN staff turn over, they currently had no one in charge of infection control.

On January 19, 2022, at 12:05 p.m. R6 stated there had been many staff out due to COVID-19 illness, and the residents had not had any COVID-19 testing done.

The licensee provided a document titled, "Employee COVID leave list" which indicated the licensee had a COVID-19 outbreak with 14 positive staff members identified from December 1, 2021, through January 22, 2022, in various departments.

The licensee's document titled COVID test log indicated facility outbreak testing of the residents

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ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

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{0 510}	Continued From page 12 did not begin until January 21, 2022, a total of 23 days after the first COVID-19 positive staff was identified. The document titled "Resident COVID Roster" indicated following the January 21, 2022, outbreak testing, three residents (R18, R22, and R23) were identified as COVID-19 positive and quarantined. The licensee's testing documentation indicated resident testing was completed on January 24, 2022, and repeated on January 27, 2022, through January 28, 2022. The documentation indicated R18 and R22 remained positive, and R23 and all remaining residents, tested negative. The outbreak testing documentation failed to include documentation of ongoing facility staff testing was being completed during facility wide outbreak testing. Facility policy and procedure title "COVID-19 - Policy 2022" section 1. d. indicated all staff must be tested for COVID bi-weekly, and a positive test resulted in quarantine for the number of days set by the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) for either vaccinated or unvaccinated symptomatic or asymptomatic staff. Section 2. Resident Screening - indicated residents were to have COVID testing completed per CDC and MDH guidelines. The facility policy and procedure lacked specific information for actions the facility would take regarding testing during an outbreak of COVID-19. CLEANING AND DISINFECTION The Minnesota Department of Health (MDH) guidance, titled COVID-19 Toolkit, Information for Long Term Care Facilities dated March 8, 2021,	{0 510}		

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{0 510}	Continued From page 13 indicated to disinfect surfaces with an EPA-registered disinfectant with a label indicating effectiveness against human Coronavirus or emerging viral pathogens. High-touch surfaces include but are not limited to: door handles, railings, light switches, remotes, phones, call buttons, medical equipment (lifts, thermometers, pulse oximeter), etc. Interim infection prevention and control recommendations for healthcare personnel curing the Coronavirus Disease 2019 (COVID-19) Pandemic updated February 2, 2022, indicated routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed, and instructed facilities to refer to a list nexternal icon on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2. On January 24, 2022, at 2:47 p.m. facility nurse consultant (RN-W) indicated the licensee had no infection control mitigation in place in regards to cleaning and disinfection, and stated they had no documentation logs available. Information was requested regarding cleaning and disinfecting of frequently touched surfaces, cleaning products used, and cleaning logs, none were provided. The licensee's policy and procedure title "COVID-19 - Policy 2022" section 4. a. indicated cleaning and disinfection logs would be	{0 510}		

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{0 510}	Continued From page 14 completed by each employee responsible for performing and documenting cleaning and disinfection tasks that were requested on their shift. The licensee's policy and procedure titled "Infection Control Program" dated October 29, 2021, indicated the infection control policies and procedures would include cleaning and disinfection of equipment and surfaces. No further information was provided.	{0 510}		
{0 620} SS=E	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 licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R20) with a medication error and for one of one resident (R21) who had an altercation with another resident (R3) 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	{0 620}		

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{0 620}	Continued From page 15 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: R20 - Medication Error The licensee failed to immediately report the December 5, 2021, medication error for R20. R20's diagnoses included diabetes, depression and chronic obstructive pulmonary disease (COPD- chronic obstruction of lung are flow that interferes with normal breathing). R20's Individual Abuse Prevention Plan Assessment dated December 17, 2021, indicated the resident was susceptible to abuse from another individual, including other vulnerable adults. R20's Medication Assessment for Safety in Self Administration dated December 30, 2021, indicated R20 was deemed unable to safely administer medications. R20's Service Plan, undated, indicated the resident received medication administration services three times daily. A Medication Error Report Form dated December 5, 2021, indicated at 6:30 p.m., unlicensed personnel (ULP)-U had accidentally administered another resident's medications to R20. The medications administered included warfarin 2.5 milligrams (mg) (blood thinner) and metoprolol tartrate 50 mg (antihypertensive medication). The licensed nurse was notified along with the	{0 620}		

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{0 620}	Continued From page 16 provider. The provider gave direction to monitor R20's vital signs every 30 minutes for two (2) hours. R20's blood pressure continued to decline with a reading at 9:28 p.m. of 80/45 and a pulse rate of 63 (ideal blood pressure is consider to be between 90/60 and 120/80; with low blood pressure considered to be lower than 90/60). R20's provider was notified again at 9:48 p.m., of R20's low blood pressure and the staff were instructed to send R20 to the emergency room to be evaluated. R20 was transferred to a nearby emergency room, evaluated and returned to the facility on December 6, 2021, without any further negative outcomes. A review of the MAARC Common Entry Point Report for the above noted incident indicated the incident had been reported to MAARC on December 14, 2021 (nine days after the incident). R21 and R3 Altercation The licensee failed to immediately report the December 22, 2021, altercation incident between R21 and R3 to MAARC. R3's diagnoses included quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's Uniform Assessment Tool dated December 29, 2021, indicated R3 needed assistance with bathing, dressing, medication administration, transferring and was wheelchair dependent. R3's Individual Abuse Prevention Plan Assessment dated December 30, 2021, indicated R3 was susceptible to abuse from another individual, including other vulnerable adults, and R3 was at risk of abusing other vulnerable adults due to his alcohol use disorder and temper.	{0 620}		

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{0 620}	Continued From page 17 R21's diagnoses included vascular dementia with behavioral disturbance and a cerebrovascular accident (CVA-stroke). R21's RN (registered nurse) Comprehensive Assessment dated November 30, 2021, indicated R21 needed assistance with dressing, toileting, bathing, and transferring. R21 had behavior issues (verbal or physical aggression) and impaired decision-making ability. R21's Individual Abuse Prevention Assessment dated December 29, 2021, indicated R21 was susceptible to abuse from another individual, including other vulnerable adults; however, was not identified as being a risk for abusing other vulnerable adults. A Resident Incident Report, undated, and written by licensed assisted living director (LALD)-A indicated on December 22, 2021, at 6:30 p.m. an incident occurred in front of the main building between R21 and R3, who both were in their power wheelchairs. The two residents started a verbal altercation and R21 hit R3 with his power wheelchair and knocked a plastic tumbler off the tray on the front of R3's wheelchair and then R21 proceeded to knock R3's phone to the ground. R3 notified the police, which they arrived two hours later and spoke to both residents and two other residents who happened to be outside at the time of the altercation. A review of the MAARC Common Entry Point Report for the above noted incident indicated the incident had been reported to MAARC on December 28, 2021 (six days after the incident). On January 20, 2022, at approximately 3:06 p.m. LALD-A verified the licensee's policy indicated reports to MAARC should be made within 24 hours of the incident. LALD-A confirmed the	{0 620}		

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{0 620}	Continued From page 18 above noted incidents had not been reported timely to MAARC. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated December 15, 2021, noted if the Assisted Living Director or Clinical Nurse Supervisor confirm the suspicion of maltreatment, they will contact the MAARC. Such report must be made no later than 24 hours after the maltreatment was suspected. No further information was provided.	{0 620}		
{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 four residents (R19) with records reviewed. This practice resulted in a level two violation (a	{0 630}		

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{0 630}	Continued From page 19 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: R19's Assessment for Client Vulnerability, Safety and Risk to Others dated March 2, 2019, lacked an individual review or assessment of R19's susceptibility of abuse by another individual, including self-abuse. R19's diagnoses included, but were not limited to, Alzheimer's disease, dementia, diabetes, and anxiety. R19's service plan dated September 20, 2018, through July 31, 2019, indicated R19 received services which included medication administration, assistance with bathing, grooming, dressing, incontinent cares, housekeeping, laundry, meals, and activities. On January 20, 2022, at approximately 3:45 p.m. Control Officer (CO)-M confirmed R19's individual abuse prevention plan did not meet the required content to include susceptibility of abuse by others, and self-abuse. The licensee's Individual Abuse Prevention Plan policy dated December 10, 2021, indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including self-abuse.	{0 630}		

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{0 630}	Continued From page 20 No further information provided.	{0 630}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of three employees (unlicensed personnel (ULP)-H and ULP-F), and the licensee failed to ensure completion of TB education was completed for one of two ULP (ULP-F), 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	{0 660}		

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{0 660}	Continued From page 21 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's TB risk assessment was completed November 11, 2021, and was determined to be a low risk level. ULP-H ULP-H's employee record lacked documentation of a complete two step screening for active/latent TB. ULP-H's record included documentation of a negative TST on July 14, 2021; however, a second TST was not completed. ULP-H started employment on December 11, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 20, 2022, at approximately 4:08 p.m. control officer (CO)-M confirmed ULP-H had not received a second step TST, as required. ULP-F ULP-F's employee record lacked documentation of a complete two step screening for active/latent TB. ULP-F's record included documentation of a negative TST on November 13, 2020; however, a second TST was not completed. ULP-F started employment on October 29, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-F's employee record lacked documentation of completed TB education from time of hire or annually.	{0 660}		

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{0 660}	Continued From page 22 On January 20, 2022, at 12:30 p.m. CO-M confirmed ULP-F had not received a second step TST, as required, and had not completed the required TB education. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's TB Prevention Control policy, undated, indicated the RN was responsible for establishing and maintaining the TB prevention and control program, including establishment of an infection control team, completion of a written TB risk assessment, screening of staff for TB and education of staff regarding TB signs and symptoms, the infection control plan and other communicable diseases. In addition, the policy indicated staff would be screened for TB with a two-step TST or single interferon gamma release assay (IRGA) for M. tuberculosis. The policy further indicated education of assisted living staff would include TB signs and symptoms, the infection control plan and other communicable diseases. No further information was provided.	{0 660}		

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0 810	Continued From page 23	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: Based on observation, interview, and record review, the licensee failed to include the location	0 810		

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0 810	Continued From page 24 and number of resident rooms in the fire safety and evacuation plans. This had the potential to affect all residents and staff. 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 January 19, 2022, between 11:45 a.m. and 12:30 p.m., survey staff toured the facility with operations (O)-P and maintenance(M)-L. During the tour, the following observation was made: The location and number of resident sleeping rooms were not included on the evacuation maps posted within the facility. On January 19, 2021, at approximately 12:30 p.m. controller (C)-M provided records for review. Records were reviewed by survey staff on January 19, 2021, between 12:30 p.m. and 1:00 p.m. The Emergency Operations Plan Manual dated November 2021, did not include maps with the location and number of resident sleeping rooms. On January 19, 2021, at approximately 1:10 p.m. O-P confirmed during the exit interview that the licensee failed to provide the required content within the fire safety and evacuation plans. No further information was provided.	0 810		

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0 810	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
{0 900} SS=D	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,	{0 900}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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
{0 900}	Continued From page 26 a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of four residents (R1 and R19) 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: R1 and R19's records lacked a written assisted living contract which included all of the terms concerning the provisions of the following as required: (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 In addition, R1 and R19's records lacked evidence the assisted living contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and	{0 900}		

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{0 900}	Continued From page 27 any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. R1 R1's record lacked a current service plan; however, R1's Individualized Treatment or Therapy Management Plan and Individualized Medication Management Plan dated January 4, 2022, and January 5, 2022, respectively, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, and wound care. On January 19, 2022, at approximately 11:40 a.m. a surveyor observed unlicensed personnel (ULP)-N administer R1 her scheduled morning medications. R19 R19's record lacked a current service plan; however, R19's Individualized Medication Management Plan dated March 1, 2019, indicated R19 received services which included medication administration. On January 19, 2022, at approximately 1:43 p.m. ULP-H administered R19's scheduled medications. On January 20, 2022, at approximately 3:10 p.m. licensed assisted living director (LALD)-A and consulting registered nurse (RN)-V confirmed an assisted living contract had not been developed or executed for R1 and R19 as required.	{0 900}		

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{0 900}	Continued From page 28 A request was made for a policy on assisted living contract content, and it was not provided. No further information was provided.	{0 900}		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care contract included all required content for two of two residents (R3 and R4), with	0 920		

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0 920	Continued From page 29 records reviewed. This had the potential to affect all 41 residents who received assisted living services. 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: R3 R3's Service Plan dated November 15, 2021, indicated services included assistance with activities of daily living (ADLs), medication administration, tube feeding, catheter care, range of motion, housekeeping and laundry services. R3's Resident Agreement Terms and Conditions (assisted living contract) dated November 17, 2021, lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. R4 R4's Service Plan dated November 15, 2021, indicated services included assistance with ADLs, continuous positive airway pressure (CPAP) management (machine worn at night for sleep apnea treatment), medication administration, meals, housekeeping and laundry services. R4's Resident Agreement Terms and Conditions (assisted living contract) dated November 17,	0 920		

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0 920	Continued From page 30 2021, lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. On January 20, 2022, at 3:20 p.m. licensed assisted living director (LALD)-A confirmed the same contract was used for all residents, and was missing the required content as identified above. A request was made for a policy on assisted living contract content, and it was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one days.	0 920		
{0 950} SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your	{0 950}		

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{0 950}	Continued From page 31 guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer two of four residents (R1, R19) the opportunity to identify a designated representative 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: R1 R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease.	{0 950}		

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{0 950}	Continued From page 32 R1's record lacked a current service plan; however, R1's Individualized Treatment or Therapy Management Plan and Individualized Medication Management Plan dated January 4, 2022, and January 5, 2022, respectively, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, and wound care. R19 R19's diagnoses included Alzheimer's disease, dementia, diabetes, and anxiety. R19's record lacked a current service plan; however, R19's Individualized Medication Management Plan dated March 1, 2019, indicated R19 received services which included medication administration. On January 20, 2022, at approximately 3:12 p.m. licensed assisted living director (LALD)-A confirmed R1 and R19, had not been provided the opportunity to identify a designated representative. LALD-A confirmed the resident records lacked the notice of identifying a designated representative with the required statutory language, or the documentation the resident had declined to name a designated representative. The licensee lacked a designated representative policy. No further information was provided.	{0 950}		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 33 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency to delegated tasks to include use of a sit to stand lift for one of one unlicensed personnel (ULP-H). In addition, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated task provided by the ULP for one of one resident (R19) who utilized a sit to stand lift for transfers 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).	01420		

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01420	Continued From page 34 The findings include: R19's record lacked an assessment for the proper use of a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) and to include an assessment for proper sling size per manufacturer's instructions. R19's Center Care Plan revised March 1, 2019, indicated R19 was able to safely use a cane or a walker with ambulation. R19's Center Care Plan did not include the need for the use of a sit to stand lift for transfers. R19's Service Plan dated September 20, 2018, through July 31, 2019, indicated R19 was independent with transfers, and did not include the need for a sit to stand lift for transfers. ULP-H started employment on January 1, 2021, under the comprehensive home care license, and began providing assisted living services on August 1, 2021. ULP-H's employee record lacked documentation ULP-H had been trained or demonstrated competency to use a sit to stand lift. On January 19, 2022, at approximately 1:22 p.m. ULP-H was observed to transfer R19 from the wheelchair to the toilet using the sit to stand lift. ULP-H positioned the sit to stand lift in front of R19's wheelchair in the bathroom; ULP-H placed the lift sling under R19's arms and upper torso (trunk of the body) trying to determine the correct placement and correct loop on the sling; secured the buckle in the front of the sling; and attached the sling to the lift. ULP-H positioned R1's feet on the base of the stand and instructed the resident	01420		

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01420	Continued From page 35	01420		

to grasp and hang on to the handles of the sit to stand lift, which R19 complied. During the transfer, R19 repeatedly stated she was afraid she was going fall. ULP-H cranked the lever on the sit to stand lift and raised R19 into more of a standing position and then lowered R19 on to the toilet. ULP-H stated it was the first time she used the sit to stand lift with R19, and further stated she had not been trained by the licensee on the sit to stand lift. At approximately 1:33 p.m., ULP-H attempted to use the sit to stand lift to transfer R19 from the toilet back into the wheelchair and R19 complained of pain in her legs and stomach during the transfer and expressed her fear of falling. ULP-H stopped the transfer, called for assistance from ULP-N. ULP-H explained to ULP-N she was having difficulty transferring R19 with the sit to stand lift and needed assistance to transfer R19 back into the wheelchair. ULP-H and ULP-N transferred R19 back into the wheelchair using a transfer belt with a two person assist.

R19's record lacked evidence of specific written instructions for the ULP to follow when transferring the resident with a sit to stand lift to include the size of the sling to be used.

On January 20, 2022, at approximately 8:54 a.m. RN-O verified R19's record did not include written instructions for the ULP to follow when transferring the resident with a sit to stand lift.

On January 20, 2022, at approximately 10:00 a.m. nurse consultant (RN)-V stated there were no residents residing in the facility that required a mechanical lift device for transfers. RN-V went into R19's bathroom and verified there was an older sit to stand model Invacare Get-U-Up there. RN-V stated she did not know where the sit to

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01420	Continued From page 36 stand lift came from, and staff should not be using it for transfers. RN-V verified the sit to stand sling did not indicate a size, and the arms on the sit to stand were loose and was not safe to use and was removed from R19's room. On January 20, 2020, at approximately 12:22 p.m. RN-V verified R19 did not have an assessment for the use of a sit to stand lift to determine appropriate sling size. RN-V also verified R19's chart did not include written instructions for the ULP to follow when transferring the resident with at sit to stand lift, and further verified staff were not trained on the use of the sit to stand for resident transfers. The manufacturer operating manual for the Invacare Gut-U-Up lift device was requested, but the licensee was unable to provide it. The licensee's Medication and Treatment-Administration and Delegation Policy dated December 13, 2021, indicated an RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. The policy further indicated, the ULP must demonstrate their ability to competently follow the delegated treatment to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
{01620} SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	{01620}		

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{01620}	Continued From page 37 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 days for one of four residents (R19) 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 an isolated scope (when one or a limited number of residents are affected or one or	{01620}		

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{01620}	Continued From page 38 a limited number of staff are involved or the situation has occurred only occasionally) The findings include: R19's record lacked evidence of an assessment completed by the RN in the past 90 days. R19's diagnoses included Alzheimer's disease, dementia, diabetes, and anxiety. R19's service plan dated September 20, 2018, through July 31, 2019, indicated R19 received services which included medication administration, assistance with bathing, grooming, dressing, incontinent cares, housekeeping, laundry, meals, and activities. On January 19, 2022, at approximately 1:43 p.m. unlicensed personnel (ULP)-H was observed administering R19's scheduled medications On January 20, 2022, at approximately 8:45 a.m. RN-O confirmed she had not completed any reassessments for R19 and verified R19's last comprehensive assessment was completed September 1, 2019. On January 20, 2022, at approximately 3:50 p.m. licensed assisted living director (LALD)-A and registered nurse consultant (RN)-V confirmed R19's comprehensive reassessment was not current, and the licensee was in the process of reviewing all resident records and updating resident assessments. The licensee's Assessments, Reviews, and Monitoring policy dated December 10, 2021, indicated ongoing resident reassessments and monitoring must be conducted as needed based	{01620}		

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{01620}	Continued From page 39 on changes in the needs of the resident and cannot exceed 90 calendar days form the last date of the assessment. No further information was provided.	{01620}		
{01640} SS=E	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 three of four residents' (R1, R3, and R19) service plans were developed and implemented with records reviewed.	{01640}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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
{01640}	Continued From page 40 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: R1, R3, and R19's record lacked evidence that a current service plan had been developed. R1 On August 1, 2021, R1 started to receive services under the licensee's Assisted Living with Dementia Care license. R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a current service plan; however, R1's Individualized Treatment or Therapy Management Plan and Individualized Medication Management Plan dated January 4, 2022, and January 5, 2022, respectively, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, and wound care. On January 19, 2022, at approximately 11:40 a.m. unlicensed personnel (ULP)-N was observed administering R1 her scheduled morning	{01640}		

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{01640}	Continued From page 41 medications. R3 On August 1, 2021, R3 started to receive services under the licensee's Assisted Living with Dementia Care license. R3's diagnoses included quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and alcohol abuse. R3's service plan dated November 17, 2021, lacked identification of R3's services to include tube feeding management. On January 19, 2022, at 10:25 a.m. ULP-T confirmed R3 received medications and nutrition via tube feeding. On January 20, 2022, at 3:20 p.m. licensed assisted living director (LALD)-A confirmed R3's service plan lacked a statement for tube feeding management services. R19 On August 1, 2021, R19 started to receive services under the licensee's Assisted Living with Dementia Care license. R19's diagnoses included Alzheimer's disease, dementia, diabetes, and anxiety. R19's record lacked a current service plan; however, R19's Individualized Medication Management Plan dated March 1, 2019, indicated R19 received services which included medication administration. On January 19, 2022, at approximately 1:43 p.m.	{01640}		

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{01640}	Continued From page 42 ULP-H was observed administering R19's scheduled medications. On January 20, 2022, at approximately 3:13 p.m. LALD-A and registered nurse (RN)-O confirmed R1, R3, and R19 did not have a current service plan developed and implemented as required. The licensee's Service Plan policy dated December 10, 2021, indicated all residents receiving assisted living services would have a service plan in place. Within 14 days after the date that services are first provided to a resident, the licensee would finalize a written service plan. No further information was provided.	{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	01650		

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01650	Continued From page 43 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 all required content for two of two residents (R3 and R4) 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: R3 R3's diagnoses included quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and alcohol abuse. R3's service plan dated November 17, 2021, indicated R3 received services to include medication administration, assistance with activities of daily living (ADLs), wound care, range of motion (ROM) exercises, housekeeping, laundry, and meals. The service plan lacked the	01650		

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01650	Continued From page 44 following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 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. R4 R4's diagnoses included hypertension (high blood pressure), type II diabetes mellitus, insomnia, dementia, schizoaffective disorder, depression, anxiety, and Parkinson's disease. R4's service plan dated November 15, 2021, indicated R4 received services to include medication administration, continuous positive airway pressure (CPAP) machine management (used in treatment of sleep apnea), meals, housekeeping and laundry. The service plan lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the	01650		

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01650	Continued From page 45 facility; 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 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. On January 20, 2022, at 3:20 p.m. licensed assisted living director (LALD)-A confirmed R3 and R4's service plan's lacked the above required content. The licensee's Service Plan policy dated December 10, 2021, indicated the service plan would include: the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; 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 how the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01650		

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01650	Continued From page 46 (21) days	01650		
{01700} SS=D	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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face	{01700}		

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{01700}	Continued From page 47	{01700}		

medication management assessment to include all required content for one of four residents (R19) 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:

R19's record lacked evidence the RN conducted a face-to-face review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the resident's records failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications.

R19's record lacked a current service plan; however, R19's Individualized Medication Management Plan dated March 1, 2019, indicated R19 received services which included medication administration.

R19's diagnoses included diabetes, dementia, Alzheimer's, chronic kidney disease, hypertension, heart failure, and anxiety.

R19's prescribing orders dated December 29, 2021, included orders for the following medications: two medications to treat insomnia, one medication to treat Alzheimer's disease, one

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{01700}	Continued From page 48 medication to treat fungal skin infections, one medication to treat dandruff, one medication to treat treat fluid retention (edema) and swelling, and one medication to treat vitamin D deficiency. On January 19, 2022, at approximately 1:43 p.m. ULP-H was observed administering R19's scheduled medications. On January 20, 2022, at approximately 3:45 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-O confirmed a face-to-face medication management assessment had not been completed for R19 who received medication management services, to include all the required content as noted above. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated December 13, 2021, indicated prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct and assessment to determine what medication management services will be provided and how the services will be provided. The policy indicated the following: -assessment must be conducted face to face with the resident by the RN; -the assessment must include 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; -the RN will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and ,	{01700}		

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{01700}	Continued From page 49 at a minimum, annually; and -the RN will document in the residents record any refusal for an assessment for medication management by the resident. No further information was provided.	{01700}		
{01730} SS=D	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	{01730}		

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{01730}	Continued From page 50 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan to include all required content for two of four residents (R3 and R19) 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's diagnoses included quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and alcohol abuse. R3's service plan, dated November 17, 2021, lacked identification of tube feeding	{01730}		

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{01730}	Continued From page 51 administration and flushes as services recieved by R3. R3's record lacked prescriber orders for tube feeding and tube feeding flushes; however, R3's Inividualized Medication Management Plan and Uniform Assessment Tool dated November 2, 2021 and December 29, 2021 respectively, indicated R3's treatments included Osmolite 90 milliliters (ml)/12 hours. On January 19, 2022, at 10:25 a.m. unlicensed personnel (ULP)-T confirmed R3 received Osmolite daily and water flushes after medications via feeding tube. ULP-T stated she would administer as much water with medications and after medications as R3 instructed her to administer. ULP-T confirmed there were no instructions in R3's Medication Administration Record (MAR) on how much water should be administered. On January 20, 2022 at 3:30 p.m., licensed assisted living director (LALD)-A confirmed R3's service plan lacked a statement of services to include medication administration via tube feeding and tube feeding flushes. R19 R19's diagnoses included diabetes, dementia, Alzheimer's, chronic kidney disease, hypertension, heart failure, and anxiety. R19's record lacked a current service plan; however, R19's Individualized Medication Management Plan dated March 1, 2019, indicated R19 received services which included medication administration. R19's prescribing orders dated December 29,	{01730}		

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{01730}	Continued From page 52 2021, included orders for the following medications: two medications to treat insomnia, one medication to treat Alzheimer's disease, one medication to treat fungal skin infections, one medication to treat dandruff, one medication to treat fluid retention (edema) and swelling, one medication to treat vitamin D deficiency, and one mild pain reliever. On January 19, 2022, at approximately 1:43 p.m. ULP-H was observed administering R19's scheduled medications. R19 lacked a service plan to include a written statement of the medication management services the resident was provided. In addition, R19's medication management record did not include a current medication management plan with the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and	{01730}		

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{01730}	Continued From page 53 - completion of medication reconciliation. On January 20, 2022, at approximately 3:45 p.m. LALD-A and registered nurse (RN)-O confirmed R19 did not have a medication management plan to include the above noted content as required. The licensee's Medication Management Individualized Plan policy dated December 13, 2021, indicated the facility would prepare and include in the service plan a written statement of the medication management services that would be provided to the resident. The current individualized medication management record would contain the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. No further information was provided.	{01730}		

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{01760}	Continued From page 54	{01760}		
{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 observation, interview, and record review, the licensee failed to ensure documentation of medications administered was maintained for one of four residents (R3) and failed to ensure one of two unlicensed personnel (ULP-H) followed the the steps of the medication administration process while administering medications as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	{01760}		

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{01760}	Continued From page 55 The findings include: R3 R3's diagnoses included quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and alcohol abuse. R3's record lacked prescriber orders for tube feeding and tube feeding flushes; however, R3's Individualized Medication Management Plan and Uniform Assessment Tool dated November 2, 2021 and December 29, 2021 respectively, indicated R3's regimen included Osmolite 90 milliliters (ml)/12 hours. R3's medication administration record (MAR) dated January 1, 2022, through January January 20, 2022, lacked documentation R3's Osmolite had been administered and feeding tube had been flushed. On January 19, 2022, at 10:25 a.m. ULP-T confirmed R3 received Osmolite daily and water flushes after medications via feeding tube. ULP-T stated she did not document the services as there was not a place to document in R3's record. On January 20, 2022, at approximately 3:40 p.m. consulting RN (RN-V) confirmed R3's record lacked documentation of feeding tube administration and flushes and stated orders would need to be reviewed and clarified. ULP-H R19's diagnoses included, but were not limited to, Alzheimer's disease, dementia, diabetes, and anxiety. R19's service plan dated September 20, 2018, through July 31, 2019, indicated R19 received	{01760}		

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{01760}	Continued From page 56 services which included, but were not limited to, medication administration. R19's prescriber orders dated December 29, 2021, indicated R19 had an order for buspirone (medication to treat anxiety) 10 milligrams (mg) one tablet in the morning and early afternoon. On January 19, 2022, at approximately 1:43 p.m. ULP-H was observed preparing R19's buspirone for administration. ULP-H placed R19's buspirone in a medication cup, then documented in R19's electronic medication administration record (EMAR) indicating R19's medication was given. ULP-H then administered R19's scheduled buspirone. ULP-H confirmed she documented the administration of R19's buspirone prior to administration because she knew R19 would take her medications. On January 20, 2022, at approximately 3:49 p.m. licensed assisted living director (LALD)-A stated staff were expected to document in the resident's record the administration of medications after the medications were administered to the residents. The licensee's Medications and Treatment Record-Documentation and Refusal policy dated December 13, 2021, indicated documentation of medications/treatments/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed. No further information was provided.	{01760}		
{01770} SS=D	144G.71 Subd. 9 Documentation of medication setup	{01770}		

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{01770}	Continued From page 57 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document all required content for medication set up for one of one resident (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, 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: R7's diagnoses included adjustment disorder with depressed mood, chronic pain syndrome, insomnia and neuropathy (disease of the nerves causing numbness and weakness). R7's service plan dated January 11, 2022, indicated R7 received twice monthly medication setup by a licensed nurse. R7's prescriber orders dated June 17, 2021, August 27, 2021, and November 4, 2021, included the following orders: atorvastatin 40 milligrams (mg) by mouth once a day for history of stroke; clopidegrel 75 mg per day for history of stroke; acetaminophen 500 mg, take 1000 mg by mouth three times per day for pain; amitriptyline	{01770}		

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{01770}	Continued From page 58	{01770}		

25 mg by mouth at bedtime for depression; finasteride 5 mg by mouth daily for benign nodular prostatic hyperplasia; gabapentin 300 mg by mouth three times a day for neuropathy; levothyroxine 137 micrograms (mcg) by mouth daily for hypothyroidism; magnesium hydroxide 400 mg/ 5 milliliter (ml), take 30 ml by mouth daily as needed for constipation; miratazapine 15 mg by mouth at bedtime for depression; Nystatin 100,000 units/gram, apply topically twice daily as needed for itching or rash; omperazole 20 mg by mouth twice daily for gastric reflux disease; Toprol XL 100 mg by mouth daily for high blood pressure; (mg) calcium 600 mg by mouth twice a day for osteopenia; and vitamin D3 2000 units by mouth once a day for osteopenia.

R7's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup.

On January 19, 2022, at 10:25 a.m. unlicensed personal (ULP)-T confirmed the licensed nurses setup R7's medications.

On January 20, 2022, at 2:45 p.m. consulting registered nurse (RN)-V confirmed R6's record lacked documentation of the above requirements for medication setup.

The licensee's Medication Management - Dosage Box Setup policy dated December 13, 2021, indicated a licensed nurse would assure medication orders were transcribed onto a medication administration record (MAR) to include: dates of medication setup, medication name, quantity of dose, times to be administered,

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{01770}	Continued From page 59 route of administration, name of the person completing the medication setup, visual description of medication and drug classification and special precautions. No further information was provided.	{01770}		
{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 obtain current written or electronically recorded prescription orders to include tube feeding administration and flushes for one of one resident (R3) 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: R3's diagnoses included quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and alcohol abuse.	{01820}		

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{01820}	Continued From page 60 R3's record lacked prescriber orders for tube feeding and tube feeding flushes; however, R3's Individualized Medication Management Plan and Uniform Assessment Tool dated November 2, 2021 and December 29, 2021 respectively, indicated R3's regimen included Osmolite 90 milliliters (ml)/12 hours.. On January 19, 2022, at 10:25 a.m. unlicensed personnel (ULP)-T confirmed R3 received Osmolite daily and water flushes after medications via feeding tube. ULP-T stated she would administer as much water with medications and after medications as R3 instructed her to administer. ULP-T confirmed there were no instructions in R3's Medication Administration Record (MAR) on how much water should be administered. On January 20, 2022, at approximately 3:40 p.m. consulting registered nurse (RN)-V confirmed R3's record lacked documentation of feeding tube administration and flushes, and further stated orders would need to be reviewed and clarified. The licensee's Medication & Treatment Orders policy dated December 13, 2021, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided.	{01820}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	{01880}		

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{01880}	Continued From page 61 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 manufacturer's instructions for four of four medication refrigerators (Aspen, Building 1, Building 2, and Nurse Office). 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: Aspen Refrigerator On January 19, 2022, at approximately 9:30 a.m. the surveyor observed the refrigerator in the Aspen medication room with registered nurse (RN)-O. RN-O confirmed the refrigerator temperature was 40 degrees Fahrenheit (F) and confirmed the refrigerator temperature monitoring log was not completed for each shift. RN-O stated her expectation was the temperature was to be monitored every shift or three times a day. The refrigerator contained: - five (5) unopened Humulin insulin pens; - five (5) unopened Basaglar insulin pens; - nine (9) unopened Lantus insulin pens; and - 15 unopened Novolog insulin pens.	{01880}		

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{01880}	Continued From page 62 The manufacturer's instructions for Humulin insulin pens dated November 2019, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Humulin to freeze. The manufacturer's instructions for Basaglar insulin pens dated July 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Basaglar to freeze. The manufacturer's instructions for Lantus insulin pens dated December 2019, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog dated June 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze. The Aspen Medication Refrigerator Temperature Log dated January 2022, lacked documentation of the refrigerator temperature for 14 of 54 opportunities. Building 1 Refrigerator On January 19, 2022, at approximately 9:40 a.m. the surveyor observed the refrigerator in Building 1 medication room with RN-O. RN-O confirmed the refrigerator temperature was 40 degrees F and confirmed the refrigerator temperature monitoring log was not completed for each shift. The refrigerator contained: - three (3) unopened Novolog insulin pens; and - eight (8) unopened Basaglar insulin pens.	{01880}		

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{01880}	Continued From page 63 The Building 1 Medication Refrigerator Temperature Log dated January 2022, lacked documentation of the refrigerator temperature for 46 of 54 opportunities. Building 2 Refrigerator On January 19, 2022, at approximately 9:45 a.m. the surveyor observed the refrigerator in Building 2 medication room with RN-O. RN-O confirmed the refrigerator temperature was 40 degrees F and confirmed the refrigerator temperature monitoring log was not completed for each shift. The refrigerator contained: - four (4) unopened Lantus insulin pens. The Building 2 Medication Refrigerator Temperature Log dated January 2022, lacked documentation of the refrigerator temperature for 53 of 54 opportunities. Nurse Office Refrigerator On January 19, 2022, at approximately 10:00 a.m. the surveyor observed the refrigerator in the nurse office with RN-O. RN-O confirmed the refrigerator temperature was 38 degrees F and confirmed the refrigerator temperature monitoring log was not completed for each shift. The refrigerator contained: - two (2) unopened tubes of Lidocaine gel; and - two (2) unopened Basaglar insulin pens. The manufacturer's instructions for Lidocaine dated January 2022, indicated to store Lidocaine gel at room temperature (59-86 degrees F). Protect from freezing. The Nurse Office Medication Refrigerator Temperature Log dated January 2022, lacked documentation of the refrigerator temperature for	{01880}		

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{01880}	Continued From page 64 39 of 54 opportunities. The Medication Refrigerator Temperature Log form, undated, included instructions to record the time, temperature, and initial with each recorded temperature and to check three times per day (morning hours, evening hours and nighttime hours). On January 20, 2022, licensed assisted living director (LALD)-A stated they had chosen to check all medication refrigerators three times a day in hopes of ensuring they were monitored at least once a day. LALD-A confirmed the instructions on the Medication Refrigerator Temperature Log were not being followed. The licensee's Medication Storage policy dated December 13, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen) and refrigerator will be monitored for temperature compliance. No further information was provided.	{01880}		
{01890} SS=E	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	{01890}		

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{01890}	Continued From page 65 review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for four of four residents (R6, R12, R20, and 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 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: On January 19, 2020, at approximately 9:30 a.m. a tour of the facility was conducted with registered nurse (RN)-O, including review of the locked medication cabinets in Aspen, Building 1 and Building 2. The following was observed, and confirmed with NR-O: R6 R6's Basaglar 100 units/ml insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. R6's Ventolin HFA inhaler lacked a label to indicate when the inhaler was opened and when the inhaler would expire. R12 R12's Flovent Diskus 250 micrograms (mcg) inhaler lacked a label to indicate when the inhaler was opened and when the inhaler would expire.	{01890}		

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{01890}	Continued From page 66 R20 R20's Symbicort inhaler lacked a label to indicate when the inhaler was opened and when the inhaler would expire. R20's Humulin 100 units/ml insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. R23 R23's Albuterol inhaler lacked a label to indicate when the inhaler was opened and when the inhaler would expire. R23's Lantus 100 units/ml insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. In addition, the insulin pen lacked the original prescription label. R23's Trelegy inhaler lacked a label to indicate when the inhaler was opened and when the inhaler would expire. The manufacturer's instructions for Basaglar insulin pens dated September 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Ventolin/Abuterol inhalers dated January 2022, directed to discard the inhaler 12 months after removal from the foil pouch. The manufacturer's instructions for Flovent Diskus dated January 2022, directed to discard the inhaler two months after removal from the foil pouch.	{01890}		

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{01890}	Continued From page 67 The manufacturer's instructions for Symbicort inhalers dated July 26, 2021, directed to discard the inhaler three months after removal from the foil pouch. The manufacturer's instructions for Humulin dated November 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Trelegy inhaler dated November 2020, directed to discard the inhaler six weeks after removal from foil tray. On September 27, 2021, at approximately 11:15 a.m. LPN-C confirmed all medications should have original labels and be dated after opening with open date and expiration date. The licensee's Storage of Medications policy reviewed December 12, 2021, indicated medications would be stored in their original packaging, labeled and legible. No further information was provided.	{01890}		
{01940} SS=D	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	{01940}		

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{01940}	Continued From page 68 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 the 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 cause serious injury, impairment, or death), and	{01940}		

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{01940}	Continued From page 69 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: R1- BLOOD GLUCOSE MONITORING AND PREVALON BOOT R1's record lacked evidence of a written statement on the resident's service plan for the services being provided to include blood glucose (sugar) monitoring and Prevalon boot (a protective boot that completely offloads the heel to help prevent the development of heel pressure ulcers) and a complete individualized treatment or therapy plan for the Prevalon boot. R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of the left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's prescriber orders dated January 3, 2022, included an order for blood glucose monitoring to be completed two (2) times a day twice weekly and for Prevalon boot to be placed while in bed to offload pressure. R1's Uniform Assessment Tool dated January 3, 2022, indicated R1's treatments included glucose monitoring two (2) times a day twice weekly and heel boot to be placed when in bed. R1's Treatment Administration Record (TAR) dated January 1, 2022, through January 18, 2022, directed for R1's blood glucose to be monitored twice a day on Tuesday and Thursday	{01940}		

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{01940}	Continued From page 70 of each week and the Prevalon boot to be placed when the resident was in bed to offload pressure. R1's record lacked a current service plan, thus lacked a written statement of the treatment services the resident received to include blood glucose monitoring and Prevalon boot. R1's Individualized Treatment or Therapy Management Plan dated January 4, 2022, did not include the following required content for R1's Prevalon boot: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel (ULP); - procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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. On January 20, 2022, at approximately 3:13 p.m. licensed assisted living director (LALD)-A and RN-O confirmed R 1 did not have a current service plan developed. On January 20, 2022, at approximately 3:22 p.m. RN-O confirmed R1 did not have a treatment and therapy plan developed for R1's Prevalon boot. The licensee's Treatment and Therapy Management Plan policy dated December 13, 2021, indicated for each resident receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be	{01940}		

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{01940}	Continued From page 71 provided to the resident. The licensee will develop and maintain a current individualized treatment and therapy management record for each resident which included the following: a statement of the type of services that will be provided; documentation of specific resident instructions relating to the treatment or therapy administered; identification of treatment or therapy tasks that will be delegated to ULP; procedures to notify a RN; any resident-specific requirements relating to documentation of treatment 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 management record must be current and updated when there are changes. No further information was provided.	{01940}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment	{01960}		

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{01960}	Continued From page 72 administration for one of two residents (R1) reviewed who received 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: R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's prescriber orders dated January 3, 2022, included an order for blood glucose monitoring to be completed two (2) times a day twice weekly and for Prevalon boot (a protective boot that completely offloads the heel to help prevent the development of heel pressure ulcers) to be placed while in bed to offload pressure. R1's Uniform Assessment Tool dated January 3, 2022, indicated R1's treatments included glucose monitoring two (2) times a day twice weekly and heel boot to be placed when in bed. R1's Treatment Administration Record (TAR) dated January 1, 2022, through January 18, 2022, directed for R1's blood glucose to be monitored twice a day on Tuesday and Thursday of each week and the Prevalon boot to be placed	{01960}		

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{01960}	Continued From page 73 when the resident was in bed to offload pressure (this was to be documented three times a day-every shift). R1's treatment administration record (TAR) and medication administration record (MAR) dated January 1, 2022, through January 18, 2022, indicated blood glucose checks had been conducted two times a day twice a week (on Tuesdays and Thursdays); however, R1's record lacked documentation of the results of the blood glucose check seven (7) out of the 10 times R1's blood glucose had been completed as ordered above. R1's TAR and documented services report dated January 1, 2022, through January 18, 2022, lacked documentation R1's Prevalon boot had been placed when in bed on 37 of the 54 opportunities. On January 20, 2022, at approximately 3:26 p.m. registered nurse (RN)-O confirmed R1's record lacked documentation of her blood glucose monitoring results and Prevalon boot placement as noted above. The licensee's Treatment and Therapy Management Plan policy dated December 13, 2021, indicated for each resident receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The licensee will develop and maintain a current individualized treatment and therapy management record for each resident which included the following: a statement of the type of services that will be	{01960}		

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{01960}	Continued From page 74 provided; documentation of specific resident instructions relating to the treatment or therapy administered; identification of treatment or therapy tasks that will be delegated to ULP; procedures to notify a RN; any resident-specific requirements relating to documentation of treatment 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 management record must be current and updated when there are changes. The licensee's Medication and Treatment Record - Documentation and Refusal policy dated December 13, 2021, indicated the licensee would create and maintain a correct and accurate treatment/therapy record for each resident receiving treatments or therapies. If a treatment was not completed as prescribed, documentation must include the reason why it was not completed and any follow up notifications or procedures that were provided. A resident's MAR and TAR would be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided.	{01960}		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).	02070		

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02070	Continued From page 75 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility was staffed twenty four hours a day, seven days a week in the key pad secured unit (Building 2). This had the potential to affect all residents residing at the facility and resulted in an immediate correction order on January 19, 2022, at 4:50 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility with dementia care. During the facility tour at approximately 9:25 a.m., a staffing plan was observed on each unit. The staffing plan for Building 2 indicated one unlicensed personnel (ULP) was scheduled per unit per shift; and in Aspen and building 1, one ULP was scheduled for the day and evening shifts, plus one shared ULP float for the day and evening shifts; and one ULP to cover both areas for the overnight shift. On January 19, 2022, at approximately 11:42 a.m. ULP-H was observed exiting the secured unit and walked down the hallway. No other staff	02070		

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02070	Continued From page 76	02070		

were observed on the secured unit. At approximately 11:43 a.m., ULP-H and ULP-T returned to the secured unit.

On January 19, 2022, at approximately 12:04 p.m. ULP-H stated she called on her Walkie-Talkie for assistance in getting a resident up and didn't get a response so she had to leave the secured unit to get assistance since she was the only staff working on the secured unit.

On January 19, 2022, at approximately 1:22 p.m. ULP-H was observed entering the secured unit. ULP-H stated she had to leave the secured unit to get the breakfast cart from the kitchen and then again to bring the cart of dirty dishes back to the kitchen. ULP-H stated the residents on the secured unit are okay to be left alone for a few minutes.

On January 19, 2022, at approximately 2:18 p.m. registered nurse (RN)-O stated there was no set amount of time staff could be off the secured unit. RN-O stated there were only two staff on the night shift and there were times ULP scheduled on the secured unit would have to leave the unit to help out on the other units.

On January 19, 2022, at approximately 2:47 p.m. maintenance-L measured the distance from the secure locked unit to the dining room to be 110 feet.

On January 19, 2022, at approximately 3:32 p.m. ULP-Q was observed leaving the secured unit and no other staff were present in the unit.

On January 19, 2022, at approximately 3:34 p.m. ULP-Q returned to the secured unit. ULP-Q stated there were times during her shift she would

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02070	Continued From page 77 have to leave the secured unit to assist ULP on other units. On January 19, 2022, at approximately 3:34 p.m. ULP-Q stated there was only one ULP scheduled to work on the secured unit for each shift since there were only six residents. ULP-Q stated she would sometimes leave the secured unit to go help out on other the units if needed. ULP-Q further stated she had left the secured unit in the past for about five minutes to go outside to smoke. On January 19, 2022, at approximately 4:35 p.m. scheduler-M stated she tried to schedule three ULP for the campus at night; however, sometimes there were only two scheduled. The ULP schedule from January 1 through 19, 2022, was reviewed. There were nine dates with only two staff scheduled for the night shift. The licensee's Arbor Park Assisted Living Direct-Care Staffing Plan, undated, indicated Building 1 and Aspen were co-scheduled with two staff for day and evening shifts, and one staff for overnight shift, while Building 2 was scheduled with one staff for each shift. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's observation on January 20, 2022, and review by evaluation supervisor on January 20, 2022, however noncompliance remains at a scope and severity of F.	02070		

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02070	Continued From page 78 TIME PERIOD FOR CORRECTION: Seven (7) days	02070		
{02140} SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview with licensed assisted living director (LALD)-A on January 20, 2022, at 4:00 p.m. LALD-A confirmed the licensee did not	{02140}		

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{02140}	Continued From page 79 currently have an assigned staff person to oversee staff training in the care of individuals with dementia, as it was LALD-A's understanding that Educare dementia training met the requirements and was being assigned to all staff. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided.	{02140}		
{02170} SS=F	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; (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;	{02170}		

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{02170}	Continued From page 80 (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 have an evaluation for an activity plan for one of four residents (R1) who received services under an assisted living with dementia care license 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: R1 record lacked an activity evaluation and plan to include all required content. R1 R1's diagnoses included diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate),	{02170}		

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{02170}	Continued From page 81 and chronic kidney disease. R1's Uniform Assessment Tool dated January 3, 2022, indicated R1's customary routines important to quality of life included bingo, water plants and reading. R1's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. On January 20, 2022, at approximately 3:31 p.m. licensed assisted living director (LALD)-A and registered nurse consultant (RN)-V confirmed the licensee had not completed an activity evaluation or developed a plan for any residents yet. This was something they were planning to have their activity staff member complete. The licensee's Life Enrichment Programs, Activities and Outdoor Space policy dated December 15, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: past and current interests; current abilities and skills; emotional and social needs and patterns; physical abilities and limitations; adaptations necessary for the resident to participate; and	{02170}		

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{02170}	Continued From page 82 identification of activities for behavioral interventions. An individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided.	{02170}		
{02310} SS=D	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 observation, interview and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for one of one resident (R19) who utilized a sit to stand lift for transfers 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: R19's record lacked an assessment for the proper use of the sit to stand lift (a mechanical device to aide in transfer of persons with limited	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	R 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{02310}	Continued From page 83 weight bearing ability) used for resident transfers. R19's diagnoses included dementia, Alzheimer's disease, diabetes, and anxiety. R19's last quarterly assessment completed September 1, 2019, indicated R19 required only reminders and cues during transferring and did not indicate R19 transferred with the use of a sit to stand lift. R19's Center Care Plan revised March 1, 2019, indicated R19 was able to safely use a cane or a walker with ambulation. R19's Center Care Plan did not include the need for the use of a sit to stand lift for transfers. On January 19, 2022, at approximately 1:22 p.m. unlicensed personnel (ULP)-H was observed to transfer R19 from the wheelchair to the toilet using the sit to stand lift. ULP-H positioned the sit to stand lift in front of R19's wheelchair in the bathroom; ULP-H placed the lift to sling under R19's arms and upper torso (trunk of the body) trying to determine the correct placement and correct loop on the sling; secured the buckle in the front of the sling; and attached the sling to the lift. ULP-H positioned R1's feet on the base of the stand and instructed the resident to grasp and hang on to the handles of the sit to stand lift, which R19 complied. During the transfer, R19 repeatedly stated she was afraid she was going fall. ULP-H cranked the lever on the sit to stand lift and raised R19 into more of a standing position and then lowered R19 on to the toilet. ULP-H stated it was the first time she used the sit to stand lift with R19, and further stated she had not been trained by the licensee on using the sit to stand lift. At approximately 1:33 p.m., ULP-H attempted to use the sit to stand lift to transfer	{02310}		

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{02310}	Continued From page 84 R19 from the toilet back into the wheelchair, but R19 complained of pain in her legs and stomach during the transfer and expressed her fear of falling. ULP-H stopped the transfer, and called for assistance from ULP-N. ULP-H explained to ULP-N she was having difficulty transferring R19 with the sit to stand lift and needed assistance to transfer R19 back into the wheelchair. ULP-H and ULP-N transferred R19 back into the wheelchair using a transfer belt with a two person assist. On January 20, 2022, at approximately 8:54 a.m. RN-O verified R19's record lacked an assessment for the use of a sit to stand lift for transfers. On January 20, 2022, at approximately 10:00 a.m. registered nurse consultant (RN)-V verified R19 had a sit to stand model Invacare Get-U-Up in R19's bathroom. RN-V verified the sit to stand sling did not indicate a size, the arms on the sit to stand lift were loose and was not safe to use, and it was removed from R19's room. On January 20, 2020, at approximately 12:22 p.m. RN-V verified R19 did not have an assessment for the use of a sit to stand lift to determine appropriate use and sling size. The licensee's Medication and Treatment-Administration and Delegation Policy dated December 13, 2021, indicated prior to an ULP providing a delegated treatment, the RN must conduct a face-to-face assessment to determine what treatment services will be provided and how those services will be provided. The policy further indicated, the RN must specify, in writing, specific instructions for each resident and document those instruction in the resident's	{02310}		

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{02310}	Continued From page 85 record. No further information was provided.	{02310}		
{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	{03000}		

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{03000}	Continued From page 86 (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 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 timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R20) with a medication error and for one of one resident (R21) who had an altercation with another resident (R3) 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: R20 - Medication Error The licensee failed to immediately report the	{03000}		

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{03000}	Continued From page 87 December 5, 2021, medication error for R20. R20's diagnoses included diabetes, depression and chronic obstructive pulmonary disease (COPD- chronic obstruction of lung are flow that interferes with normal breathing). R20's Individual Abuse Prevention Plan Assessment dated December 17, 2021, indicated the resident was susceptible to abuse from another individual, including other vulnerable adults. R20's Medication Assessment for Safety in Self Administration dated December 30, 2021, indicated R20 was deemed unable to safely administer medications. R20's Service Plan, undated, indicated the resident received medication administration services three times daily. A Medication Error Report Form dated December 5, 2021, indicated at 6:30 p.m., unlicensed personnel (ULP)-U had accidentally administered another resident's medications to R20. The medications administered included warfarin 2.5 milligrams (mg) (blood thinner) and metoprolol tartrate 50 mg (antihypertensive medication). The licensed nurse was notified along with the provider. The provider gave direction to monitor R20's vital signs every 30 minutes for two (2) hours. R20's blood pressure continued to decline with a reading at 9:28 p.m. of 80/45 and a pulse rate of 63 (ideal blood pressure is consider to be between 90/60 and 120/80; with low blood pressure considered to be lower than 90/60). R20's provider was notified again at 9:48 p.m., of R20's low blood pressure and the staff were instructed to send R20 to the emergency room to be evaluated. R20 was transferred to a nearby	{03000}		

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{03000}	Continued From page 88	{03000}		

emergency room, evaluated and returned to the facility on December 6, 2021, without any further negative outcomes.

A review of the MAARC Common Entry Point Report for the above noted incident indicated the incident had been reported to MAARC on December 14, 2021 (nine days after the incident).

R21 and R3 Altercation
The licensee failed to immediately report the December 22, 2021, altercation incident between R21 and R3 to MAARC.

R3's diagnoses included quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence.

R3's Uniform Assessment Tool dated December 29, 2021, indicated R3 needed assistance with bathing, dressing, medication administration, transferring and was wheelchair dependent. R3's Individual Abuse Prevention Plan Assessment dated December 30, 2021, indicated R3 was susceptible to abuse from another individual, including other vulnerable adults, and R3 was at risk of abusing other vulnerable adults due to his alcohol use disorder and temper.

R21's diagnoses included vascular dementia with behavioral disturbance and a cerebrovascular accident (CVA-stroke).

R21's RN (registered nurse) Comprehensive Assessment dated November 30, 2021, indicated R21 needed assistance with dressing, toileting, bathing, and transferring. R21 had behavior issues (verbal or physical aggression) and impaired decision-making ability. R21's Individual Abuse Prevention Assessment dated December

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{03000}	Continued From page 89	{03000}		

29, 2021, indicated R21 was susceptible to abuse from another individual, including other vulnerable adults; however, was not identified as being a risk for abusing other vulnerable adults.

A Resident Incident Report, undated, and written by licensed assisted living director (LALD)-A indicated on December 22, 2021, at 6:30 p.m. an incident occurred in front of the main building between R21 and R3, who both were in their power wheelchairs. The two residents started a verbal altercation and R21 hit R3 with his power wheelchair and knocked a plastic tumbler off the tray on the front of R3's wheelchair and then R21 proceeded to knock R3's phone to the ground. R3 notified the police, which they arrived two hours later and spoke to both residents and two other residents who happened to be outside at the time of the altercation.

A review of the MAARC Common Entry Point Report for the above noted incident indicated the incident had been reported to MAARC on December 28, 2021 (six days after the incident).

On January 20, 2022, at approximately 3:06 p.m. LALD-A verified the licensee's policy indicated reports to MAARC should be made within 24 hours of the incident. LALD-A confirmed the above noted incidents had not been reported timely to MAARC.

The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated December 15, 2021, noted if the Assisted Living Director or Clinical Nurse Supervisor confirm the suspicion of maltreatment, they will contact the MAARC. Such report must be made no later than 24 hours after the maltreatment was suspected.

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{03000}	Continued From page 90 No further information was provided.	{03000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 2, 2021

Administrator
Arbor Park Living Center LLC
2921 6th Avenue North
Moorhead, MN 56560

RE: Conditional License Number 404596
Health Facility Identification Number (HFID) 30361
Project Number(s) SL30361015

Dear Administrator:

The Minnesota Department of Health (MDH) completed an initial evaluation on September 30, 2021, for the purpose of assessing compliance with state licensing statutes and to determine issuance of an initial license to the above mentioned provider. Based on the initial evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **March 2, 2022**.

In addition, maltreatment complaints currently under investigation will not alter this notice of conditional license.

Conditional License Issued:
MDH will issue Arbor Park Living Center LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Arbor Park Living Center LLC is in compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Arbor Park Living Center LLC will not admit any new

residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Arbor Park Living Center LLC must provide the Department:

i. A list of the names and birthdates of any individuals Arbor Park Living Center LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Arbor Park Living Center LLC will contract with an RN to provide consultation concerning all clients to whom Arbor Park Living Center LLC provides licensed assisted living services under the conditional license. The consultant must have access to all clients receiving services from Arbor Park Living Center LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Arbor Park Living Center LLC and MDH must review the RN's credentials and approve the selection. Arbor Park Living Center LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Arbor Park Living Center LLC in an effort to help Arbor Park Living Center LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Arbor Park Living Center LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Arbor Park Living Center LLC and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-696-2437 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering home care services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with home care services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the home care services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Arbor Park Living Center LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Arbor Park Living Center LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed home care services. The OOLTC will share their findings with MDH.

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

g. Corrective Action Plan: Arbor Park Living Center LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Arbor Park Living Center LLC is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If

MDH determines Arbor Park Living Center LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Arbor Park Living Center LLC's assisted living facility license, and Arbor Park Living Center LLC will correct violations identified during the evaluation to come into full compliance. If MDH determines Arbor Park Living Center LLC is not in substantial compliance, MDH may take additional enforcement action against Arbor Park Living Center LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order.

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

If you have any questions, please contact Jodi Johnson directly at: 507-696-2437.

Sincerely,

Martha Burton, MPA
DIVISION DIRECTOR

Minnesota Department of Health
Health Regulation Division

In the Matter of Arbor Park Living Center LLC
Arbor Park Living Center LLC
2921 6th Avenue North
Moorhead, MN 56560

MDH HFID # 30361
License Number 404596
Project Number(s) SL30361015

Stipulation and Consent Order:

IT IS STIPULATED AND AGREED by Arbor Park Living Center LLC and the Minnesota Department of Health ("Department" or "MDH"), that without trial or adjudication of any issue of fact or law both parties agree to enter into this agreement.

This Stipulation and Consent Order ("Stipulation"), evaluation reports, and related documents shall constitute the entire record upon which this Stipulation is based. The evaluation results and public documents dated September 30, 2021, through the date of this Stipulation, as listed below in the Facts and Law, are incorporated by reference into this Stipulation. This Stipulation is public data pursuant to Minn. Stat. § 144.051, Subd. 4 and the provisions of the Minnesota Government Data Practices Act, Minn. Stat. Ch. 13

Facts and Law:

1. Minn. Stat. § 144G.01 - Minn. Stat. § 144G.95, authorize MDH to regulate licensed assisted living facilities in Minnesota. This authority includes issuing licenses and conducting evaluations to determine if a license holder is in compliance with statutory requirements of licensed assisted living facilities.

2. Arbor Park Living Center LLC has been licensed to provide assisted living services since August 1, 2014.

3. On September 30, 2021, the Department conducted an evaluation for the purpose of assessing compliance with State licensing regulations Project Number SL30361015. This evaluation resulted in 46 order(s), including 25 Level 2 violations.

4. Maltreatment complaints currently under investigation will not alter this notice of conditional license.

<u>Current Status</u>

Arbor Park Living Center LLC Administrator Susan Bala, met informally with MDH during a conference call on October 29, 2021. During the call, MDH shared their concerns about the

evaluation completed on September 30, 2021, and provided Arbor Park Living Center LLC with the option of a stipulated agreement. During the informational conference, Arbor Park Living Center LLC shared what actions they are taking to bring Arbor Park Living Center LLC into compliance. Additional communications followed, and Arbor Park Living Center LLC decided to proceed with a stipulated agreement.

Under this agreement, Arbor Park Living Center LLC will take immediate steps to correct all violations under a conditional license. MDH plans to issue the conditional license using a stipulated agreement. In the event Arbor Park Living Center LLC is not able to meet the conditions of the license, and MDH suspends and/or revokes the license, Arbor Park Living Center LLC waives its right to a contested case proceeding under Minn. Stat. Ch. 14.

Conditional License Issued:

MDH will issue Arbor Park Living Center LLC a conditional assisted living facility license for 90 calendar days from the effective date of this Stipulation. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30 Subd. 6. Based on the results of the evaluation, MDH will determine if Arbor Park Living Center LLC is in compliance.

The following conditions apply on the conditional comprehensive license:

a. **No new substantiated maltreatment allegations:** If any new maltreatment investigations begin during the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

   Any allegations of maltreatment under investigation as of the effective date of this agreement will be subject to the enforcement process; however, these of allegations will not be considered a violation of the conditional license if substantiated.

b. **No new admissions:** Arbor Park Living Center LLC will not admit any new clients under its conditional assisted living license until the MDH removes the "no new admissions" condition. On the date the agreement is signed by Arbor Park Living Center LLC they must provide the Department:

   i. A list of the names and birthdates of any individuals Arbor Park Living Center LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current clients by location including:
      1. Name and birthdate of each client

3. Current payment source for services
4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
5. If the client is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Arbor Park Living Center LLC will contract with an RN to provide consultation concerning all clients to whom Arbor Park Living Center LLC provides licensed assisted living services under the conditional license. The consultant must have access to all clients receiving services from Arbor Park Living Center LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct client observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Arbor Park Living Center LLC and MDH must review the RN's credentials and approve the selection. Arbor Park Living Center LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Arbor Park Living Center LLC in an effort to help Arbor Park Living Center LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.95 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Arbor Park Living Center LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Arbor Park Living Center LLC and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-696-2437 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with clients and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the clients and their family members are treated;
vii. Concerns; and

viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Arbor Park Living Center LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Arbor Park Living Center LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

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

g. Corrective Action Plan: Arbor Park Living Center LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:

MDH will determine if Arbor Park Living Center LLC is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Arbor Park Living Center LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Arbor Park Living Center LLC's assisted living facility license, and Arbor Park Living Center LLC will correct violations detected during the evaluation to come into full compliance. If MDH determines Arbor Park Living Center LLC is not in substantial compliance, MDH may take additional enforcement action against Arbor Park Living Center LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Rights and Waivers:

If MDH suspends or revokes Arbor Park Living Center LLC's assisted living facility license, Arbor Park Living Center LLC may request reconsideration of the decision to suspend or revoke the license, or a contested case proceeding under Minn. Stat. Ch. 14 to the extent allowed by law. All requirements of Minn. Stat. § 144G.32, Subd. 1 and Subd. 2 apply to this reconsideration process.

Arbor Park Living Center LLC waives any right it might otherwise have to appeal the correction orders, assessed fines, and the conditions placed upon their assisted living facility license secondary to the survey findings of September 30, 2021. Additionally, Arbor Park Living Center LLC withdraws all pending appeals related to these correction orders, fines, and conditions.

Binding Effect:

This Agreement is binding upon the Parties, their employees, agents, heirs, administrators, representatives, executors, successors and assigns, and the Parties will assure that their employees, agents, heirs, administrators, representatives, executors, successors, and assignees are made aware of this agreement.

No Limited Authority:

This Stipulation does not in any way or manner limit or affect the authority of MDH to take additional enforcement action against Arbor Park Living Center LLC based on any act, conduct, or admission of Arbor Park Living Center LLC which justifies enforcement action and occurred either before or after the date of this Stipulation and which is not directly related to the facts and circumstances covered in this Stipulation.

Procedure:
This Stipulation contains the entire agreement between MDH and Arbor Park Living Center LLC, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation. Provider understands that this agreement is subject to the Division Director's approval.

Service of Agreement:

MDH will scan and provide a copy of the signed Stipulation to Arbor Park Living Center LLC. By this Stipulation, Arbor Park Living Center LLC agrees that the signed and scanned copy of the Stipulation is considered to be personal service upon Arbor Park Living Center LLC and at which time this Stipulations becomes effective. Upon any application of the Assistant Division Director, any appropriate federal or state court will enter an order of enforcement of any or all of the terms of this Stipulation.

Execution:

Arbor Park Living Center LLC has carefully read the Stipulation, understands the contents of it and signs it under its own free will:

Arbor Park Living Center LLC

_____

Susan Bala, Administrator

Dated: _____, 2021

Upon consideration of this Stipulation, by the Division Director, it is ordered that the terms in this Stipulation are adopted on this_____day of_____, 2021. This executed Stipulation will be effective on the date it is electronically received by Arbor Park Living Center LLC.

Martha Burton, MPA
DIVISION DIRECTOR

Minnesota Department of Health
Health Regulation Division

_____

Martha Burton, MPA, Division Director

Electronically Delivered

October 27, 2021

Administrator
Arbor Park Living Center LLC
2921 6th Avenue North
Moorhead, MN 56560

RE: Project Number(s) SL30361015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 30, 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

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.

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.

INFORMAL CONFERENCE
At any time, the Commissioner of Health is authorized by Minn. Stat. § 144G.20, subd. 20 to hold an informal conference to exchange information, clarify issues, or resolve issues.

The Minnesota Department of Health staff would like to schedule a conference call with Arbor Park Living Center LLC. Please contact Jodi Johnson at 507-696-2437, on or before Monday, November 1, 2021, to schedule the conference call.

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
HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, 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: SL#30361015 On, September 27, 2021 through September 30, 2021, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were 41 residents that were 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 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 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 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a 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;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (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 ensure the management officials who were in charge of the day-to-day operations, and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This has the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 27, 2021, at approximately 10:30 a.m. licensed assisted living director (LALD)-A confirmed she was responsible for and participated in the	0 250		

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0 250	Continued From page 3 day-to-day operations. LALD-A stated they were familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.40, Subd 2. The licensee failed to provide a Uniform Checklist Disclosure of Services (UDALSA) to all residents. Refer to licensing order at Statute 144G.41, Subd 1. The licensee failed to develop a staffing plan, as required. Refer to licensing order at Statute 144G.41, Subd 1. The licensee failed to comply with Minnesota Food Code, chapter 4626. Refer to licensing order at Statute 144G.41, Subd 3. The licensee failed to follow guidance related to COVID-19. Refer to licensing order at Statute 144G.41, Subd 7. The licensee failed to post information for grievances and reporting of maltreatment. Refer to licensing order at Statute 144G.42, Subd 2. The licensee failed to maintain records of quality management programs. Refer to licensing order at Statute 144G.42, Subd 6. The licensee failed to report to Minnesota Adult Abuse Reporting Center (MAARC) missing resident controlled substances. In addition, the licensee failed to implement individual abuse	0 250		

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0 250	Continued From page 4 prevention plans for all residents. Refer to licensing order at Statute 144G.42, Subd 7. The licensee failed to post information related to reporting suspected crime and maltreatment as required. Refer to licensing order at Statute 144G.42, Subd 9. The licensee failed to develop and maintain a tuberculosis (TB) prevention and control program. Refer to licensing order at Statute 144G.42, Subd 10. The licensee failed to develop all requirements for disaster planning and emergency preparedness plan. Refer to licensing order at Statute 144G.43, Subd 1. The licensee failed to ensure resident records were authenticated with titles of those who made the entries. Refer to licensing order at Statute 144G.43, Subd 3. The licensee failed to ensure all services provided to residents were documented in resident records. Refer to licensing order at Statute 144G.45, Subd 2. The licensee failed to ensure smoke alarms were present in all hallways. In addition, the licensee failed to maintain a smoking shed in good repair. Refer to licensing order at Statute 144G.50, Subd 1. The licensee failed to develop, implement, and provide a contract containing all required content to all residents. Refer to licensing order at Statute 144G.50, Subd 3. The licensee failed to ensure all residents were provided the opportunity to designate a	0 250		

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0 250	Continued From page 5 representative, as required. Refer to licensing order at Statute 144G.63, Subd 1. The licensee failed to ensure all employees had received orientation to Assisted Living statutes and rules, as required. Refer to licensing order at Statute 144G.64, (a). The licensee failed to ensure all employees had completed training in dementia care, as required. Refer to licensing order at Statute 144G.70, Subd 2. The licensee failed to ensure the RN completed assessments of all residents at the frequency required and using the Uniform Assessment Tool, as required. Refer to licensing order at Statute 144G.70, Subd 4. The licensee failed to develop and implement a service plan for all residents. Refer to licensing order at Statute 144G.71, Subd 2. The licensee failed to ensure the RN completed face-to-face medication management assessments for all residents receiving medication management services. Refer to licensing order at Statute 144G.71, Subd 5. The licensee failed to ensure each resident receiving medication management services had an individualized medication management plan containing all required content. Refer to licensing order at Statute 144G.71, Subd 7. The licensee failed to ensure specific instructions for delegated medication tasks for R3; in addition, the licensee failed to ensure ULP-F was trained and competent to complete delegated medication services of administration of medications via feeding tube.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 144G.71, Subd 8. The licensee failed to ensure medications were administered via manufacturer's instructions; in addition, the licensee failed to ensure R18's medications were correctly transcribed to the medication administration record (MAR). Refer to licensing order at Statute 144G.71, Subd 9. The licensee failed to ensure documentation of medication setup included all required content; in addition, the licensee failed to ensure ULP did not pre-dish medications prior to administration. Refer to licensing order at Statute 144G.71, Subd 10. The licensee failed to ensure a procedure had been developed for medications for unplanned time away; in addition, the licensee failed to ensure all ULP were trained and competent in how to setup medications for unplanned time away and document unplanned time away in resident records. Refer to licensing order at Statute 144G.71, Subd 13. The licensee failed to ensure prescriber orders were present for all medications for R3. Refer to licensing order at Statute 144G.71, Subd 19. The licensee failed to ensure medications were stored according to manufacturer's instructions. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to ensure time sensitive medications were dated when opened and with expiration; in addition, the licensee failed to ensure all medications beared original prescription labels. Refer to licensing order at Statute 144G.71, Subd	0 250		

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0 250	Continued From page 7 22. The licensee failed to ensure all required content for disposition of medications was documented in R5's record. Refer to licensing order at Statute 144G.71, Subd 23. The licensee failed to investigate loss/spillage of controlled substances. Refer to licensing order at Statute 144G.72, Subd 3. The licensee failed to develop and maintain an individualized therapy management plan for all residents receiving treatments and/or therapies. Refer to licensing order at Statute 144G.72, Subd 4. The licensee failed to ensure specific instructions were present for all residents receiving treatments and/or therapies. Refer to licensing order at Statute 144G.72, Subd 5. The licensee failed to ensure documentation of all treatment and/or therapy services provided to residents. Refer to licensing order at Statute 144G.72, Subd 6. The licensee failed to maintain prescriber orders for treatments and/or therapy services provided to residents. Refer to licensing order at Statute 144G.81, Subd 1. The licensee failed to failed to provide a hazard vulnerability or safety risk assessment. Refer to licensing order at Statute 144G.82, Subd 3. The licensee failed to develop and implement all policies and procedures required for assisted living facilities with dementia care. Refer to licensing order at Statute 144G.83, Subd 3. The licensee failed to appoint a dementia trainer who met all requirements.	0 250		

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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
0 250	Continued From page 8 Refer to licensing order at Statute 144G.84. The licensee failed to evaluate, develop, and implement an activity plan for all residents. Refer to licensing order at Statute 144G.90, Subd 1. The licensee failed to provide the current Assisted Living Bill of Rights to all residents. Refer to licensing order at Statute 144G.90, Subd 4. The licensee failed to post daily staffing schedules for resident review. Refer to licensing order at Statute 144G.91, Subd 4. The licensee failed to ensure a side rail was assessed for appropriateness and safety; in addition, the licensee failed to store oxygen safely. Refer to licensing order at Statute 1444.6502, Subd 8. The licensee failed to ensure required postings notifying visitors of electronic monitoring was posted at facility entrances. Refer to licensing order at Statute 626.557, Subd 3. The licensee failed to report to Minnesota Adult Abuse Reporting Center (MAARC) missing resident controlled substances. Forty-six (46) 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.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	09/30/2021

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0 430	Continued From page 9	0 430		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for four of four residents (R3, R4, 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	0 430		

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0 430	Continued From page 10 the residents). The findings include: R3, R4, R1 and R2's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R3 R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated R3 received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m. unlicensed personnel (ULP)-F was observed providing personal hygiene cares to R3. R4 R4's record lacked a service plan; however R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50	0 430		

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0 430	Continued From page 11 a.m. ULP-E was observed to provide medication administration to R4. R1 R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated R1 received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing. On September 28, 2021, at approximately 6:45 a.m., ULP-H was observed administering R1's morning medication. R2 R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated R2 received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, toileting. On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed administering R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. On September 29, 2021, at approximately 12:08 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed R1, R2, R3, R4, and all residents receiving services under the facility's license had not received a written checklist listing all services permitted under the facility's license, and the services not provided under the facility's license.	0 430		

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0 430	Continued From page 12 On September 29, 2021, at approximately 9:00 a.m., RN-B provided the licensee's policy book. The licensee lacked a policy regarding the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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	0 470		

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0 470	Continued From page 13 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 ensure the required staffing plan was developed and posted as 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 licensee held an assisted living facility with dementia care license. The facility was licensed for a bed capacity of 57 residents and had a current census of 41 residents. During the entrance conference on September 27, 2021, at approximately 10:30 a.m., registered nurse (RN)-B was identified as the clinical nurse supervisor. On September 27, 2021, at 2:00 p.m. licensed assisted living director (LALD)-A stated the staffing plan was based on case mix, although was unable to provide documentation of the staffing plan. RN-B further confirmed they had not developed or implemented a staffing plan.	0 470		

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0 470	Continued From page 14 A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 41 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	0 480		

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0 480	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 27, 2021, for the specific Minnesota Food Code deficiencies. 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 establish and maintain an effective infection control program that complies with accepted health care, medical	0 510		

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0 510	Continued From page 16 and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment) and having a testing plan. 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: EYE PROTECTION The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated on page 1 of 3, heath care worker (HCW) with face-to-face contact with COVID-19 negative clients are to wear eye protection. On September 27, 2021, at approximately 11:00 a.m. during a tour of the facility with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C, neither LALD-A nor LPN-C wore eye protection. On September 27, 2021, at approximately 1:45 p.m., unlicensed personnel (ULP)-D was observed to administer R6's afternoon medications without wearing eye protection.	0 510		

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0 510	Continued From page 17 On September 28, 2021, at 6:45 a.m., ULP-H was observed to administer R1's morning medications without wearing eye protection. On September 28, 2021, at 6:50 a.m., ULP-E was observed to administer medications to R18 without wearing eye protection. On September 28, 2021, at 7:00 a.m., ULP-E was observed to administer scheduled medications to R4 without wearing eye protection. On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed to administer R2's morning medications without wearing eye protection. On September 28, 2021, at approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting without wearing eye protection. On September 28, 2021, at 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3 without wearing eye protection. On September 28, 2021, at approximately 3:00 p.m., ULP-J was observed to be working and interacting with residents in the Oaks unit; ULP-J was not wearing eye protection. On September 28, 2021, at approximately 11:00 a.m., a sign posted in the Birch unit outside of the medication room was observed to instruct staff to wear goggles or face shields. LPN-C confirmed the sign posted in Birch informed staff they should be wearing eye protection. LPN-C was not wearing eye protection and stated she was unaware of the PPE requirements.	0 510		

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0 510	Continued From page 18 On September 29, 2021, at approximately 2:00 p.m. LALD-A stated she was unsure why staff were not wearing eye protection, "We have a big box of eye protection." FACEMASK The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated on page 1 of 3, HCW with face-to-face contact with COVID-19 negative clients are to wear a medical-grade well-fitting facemask. On September 28, 2021, at approximately 3:00 p.m. ULP-J was observed to be working and interacting with residents in the Oaks unit; ULP-J was not wearing a mask. TESTING PLAN The MDH document titled, "Covid-19 Toolkit, Information for Long Term Care Facilities," last updated March 8, 2021, indicated on page 14 facilities should make a plan for testing with local health care organizations or MDH, maintain a very low threshold for testing of ill residents and staff, and facilitate specimen collection and testing as soon as possible. On September 29, 2021, at approximately 2:10 p.m. LALD-A confirmed the licensee did not have a written testing plan developed. The licensee's policy was requested, but no provided. No further information was provided.	0 510		

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0 510	Continued From page 19 TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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).	0 550		

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0 550	Continued From page 20 The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name and email contact information for the individuals who were responsible for handling grievances, including the information for reporting suspected maltreatment to MAARC. During a facility tour on September 27, 2021, at approximately 11:40 a.m. with licensed assisted living director (LALD)-A, the main entrance and the three-unit common areas lacked the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC as required. On September 29, 2021, at approximately 1:20 p.m. LALD-A confirmed the required content noted above was not posted as required. The licensee lacked a policy regarding the required postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes	0 580		

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0 580	Continued From page 21 in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, 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 September 27, 2021, at approximately 10:50 a.m. during the entrance conference with the licensed assisted living director (LALD)-A, a request was made to review documentation of the licensee's quality management activities. LALD-A indicated the licensee had begun an organizational restructuring plan; however, LALD-A was unable to provide any documentation of ongoing quality management activities relevant to the size and services provided.	0 580		

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0 580	Continued From page 22 The licensee's Quality Management Plan dated November 24, 2020, noted the home care director would develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with the current professional standards and highest quality services for residents. Documents of the quality council would be retained in the agency files for two years and would be made available to the Minnesota Department of Health upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of one resident (R2), with record reviewed.	0 620		

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	30361	A. BUILDING: _____ B. WING _____	09/30/2021

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0 620	Continued From page 23 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 September 27, 2021, at approximately 10:50 a.m. a request was made to licensed assisted living director (LALD)-A and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2021. R2 The licensee failed to immediately report to MAARC R2's unaccounted for narcotic loss and/or spillage. R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation (irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021, included an order for morphine (a moderate to severe controlled substance pain reliever) 4 milligrams (mg) to be administered buccally (in the cheek area of the mouth) every four hours scheduled for pain and 2 mg buccally every one hour as needed for pain/dyspnea (shortness of	0 620		

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0 620	Continued From page 24 breath). On September 28, 2021, at approximately 7:45 a.m. unlicensed personnel (ULP)-H was observed to administer R2's scheduled morning medications which included two prefilled syringes of morphine 0.1 milliliters (ml) [equivalent to 4 mg of morphine]. ULP-H stated the nurse set up R2's prefilled morphine syringes. On September 28, 2021, at approximately 10:55 a.m. licensed practical nurse (LPN)-C confirmed herself and RN-B filled and setup the morphine syringes for R2. LPN-C stated the bottle of morphine was stored in the medication refrigerator in the nursing office, and not in the medication refrigerator on the unit. On September 28, 2021, at approximately 11:05 a.m. the locked medication refrigerator in the nursing office was reviewed with RN-B and LPN-C. RN-B verified there currently was 18 ml of morphine concentrate (20 mg/1 ml) in the bottle of morphine. The two (2) narcotic log forms for R2's morphine were reviewed and verified with RN-B with findings listed below: First narcotic log form - Entry dated September 8, 2021, noted there was 23 ml (equivalent to 460 mg) of morphine in the bottle; - Entry dated September 13, 2021, (no time) signed by RN-B (no dual/witnessed signature) read "found bottle had spilt in bag? 16 ml currently in bottle". (This resulted in 7 ml [equivalent to 140 mg] of morphine which was documented, but not witnessed, as being spilled.) - A second entry dated September 13, 2021, at 2:30 p.m. by RN-B indicated 5 ml of morphine had been drawn up into syringes, leaving an	0 620		

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0 620	Continued From page 25 amount of 8 ml in the bottle (according to the narcotic log, there should be 11 ml left in the bottle after the morphine was drawn up into the syringes - not the 8 ml as indicated on the narcotic log form). This was the last entry on the narcotic log form, leaving 11 ml of morphine unaccounted for (equivalent 220 mg). Second narcotic log form The second narcotic log form for R2's morphine had entries dated September 19, 2021, thru September 28, 2021. - Entry dated September 19, 2021, noted a new bottle of 30 ml of morphine was on hand and 4 ml were drawn up into syringes, leaving a new amount of 26 ml of morphine; - Entry dated September 24, 2021, noted 4 ml of morphine was drawn up into syringes, leaving a new amount of 22 ml; - Entry dated September 28, 2021, noted 4 ml of morphine 4 ml was drawn up into syringes, leaving a remaining amount of 18 ml (which was the current amount in the bottle). On September 28, 2021, at approximately 11:10 a.m. RN-B stated the licensee's policy was for two staff members to count the narcotics at the end of each shift. RN-B confirmed R2's morphine was not being counted by two staff members at the end of each shift. RN-B verified the loss and/or spillage of R2's morphine as noted above had not been investigated. On September 29, 2021, at approximately 1:10 a.m. RN-B and LALD-A confirmed a report had not been submitted to MAARC regarding R2's loss and spillage of R2's morphine, and LALD-A further verified a MAARC report should have been completed and submitted.	0 620		

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0 620	Continued From page 26 The licensee's Vulnerable Adult Reporting and Investigation Policy dated November 23, 2020, noted in accordance with state and federal vulnerable adult laws our licensee's employees would report any suspected maltreatment (abuse, neglect or financial exploitation) of residents. As soon as the resident's immediate safety has been addressed, either the staff witnessing the maltreatment or the RN in charge would notify the Common Entry Point (CEP). If neither the RN nor home care director is available to report the incident within 24 hours, the staff witness would call the CEP directly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	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 observation, interview and record review, the licensee failed to ensure an individual	0 630		

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0 630	Continued From page 27 abuse prevention plan was developed to include the required content for four of four residents (R1, R2, R3 and R4) 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: R1, R2, R3 and R4's records lacked an individual abuse prevention plan which reviewed each resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that resident and other vulnerable adults. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated R1 received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing.	0 630		

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0 630	Continued From page 28 On September 28, 2021, at approximately 6:45 a.m., unlicensed personnel (ULP)-H was observed to administer R1's morning medication. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated R2 received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, toileting. On September 28, 2021, at approximately 7:45 a.m. ULP-H was observed to administer R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however R3's "care plan" last revised June 3, 2021, indicated R3 received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m. ULP-F was observed to provide personal hygiene cares to R3.	0 630		

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0 630	Continued From page 29 R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated R4 received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50 a.m. ULP-E was observed to provide medication administration to R4. On September 29, 2021, at 12:20 p.m. registered nurse (RN)-B confirmed individual abuse prevention plans had not been completed for any of the facility's current residents. The licensee's Initial and On-going Nursing Assessment of Clients policy revised November 25, 2020, indicated an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults would be completed at time of admission. Furthermore, the policy indicated the RN would use this assessment as the basis for the resident's individual abuse prevention plan that identifies the specific measures to be taken to minimize the risk of maltreatment to the resident or other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 30 days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety 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 and interview, the licensee failed to post the required content in common areas to include: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and posting 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. 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 client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 640		

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0 640	Continued From page 31 or has the potential to affect a large portion or all of the clients). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for MAARC posted. During a facility tour on September 27, 2021, at approximately 11:40 a.m. with licensed assisted living director (LALD)-A, the three unit common areas did not have the required postings for 911 emergency number or the reporting number for MAARC. On September 28, 2021, at approximately 7:30 a.m., the portable telephone in the birch unit which could be used by the residents was observed on a table in the common living room area, and did not have the required postings for 911 emergency or the reporting number for MAARC. On September 28, 2021, at approximately 9:10 a.m., the main office telephone, which office employee (OE)-K confirmed was used by residents, did not have the required postings for 911 emergency or the reporting number for MAARC. On September 29, 2021, at approximately 1:22 p.m., LALD-A confirmed the required content noted above was not posted as required.	0 640		

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0 640	Continued From page 32 On September 29, 2021, at approximately 9:00 a.m., registered nurse (RN)-B provided the licensee's policy book. The licensee lacked a policy regarding postings that are required. 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 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 ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed TB Facility Risk Assessment,	0 660		

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0 660	Continued From page 33 screen for active and latent TB for three of four employees (registered nurse (RN)-B, unlicensed personnel (ULP)-F, and ULP-H). In addition, the licensee failed to ensure TB training was completed for two of two employees (RN-B and ULP-E) 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 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). TB RISK ASSESSMENT The licensee failed to complete a TB risk assessment, including designating and documenting a qualified person or team with primary responsibility for the TB infection control program. On September 29, 2021, at 1:30 p.m. licensed assisted living director (LALD)-A confirmed the facility had not completed a TB risk assessment as required. SCREEN FOR ACTIVE/LATENT TB RN-B RN-B's employee record lacked documentation of a complete two-step screening for active/latent TB. RN-B's record included documentation of a negative tuberculin skin test (TST) on March 5, 2021; however, a second TST was not completed. RN-B was hired on August 1, 2021, to provide direct care to residents and oversee unlicensed personnel under the assisted living	0 660		

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0 660	Continued From page 34 with dementia care license. On September 29, 2021, at 1:45 p.m. RN-B confirmed she had not completed the second TST. ULP-F ULP-F's employee record lacked documentation of a complete two step screening for active/latent TB. ULP-F's record included documentation of a negative TST on November 13, 2020; however, a second TST was not completed. ULP-F was hired on August 1, 2021, to provide direct care to residents under the assisted living with dementia care license. ULP-H ULP-H's employee record lacked documentation of a completed two step screening for active/latent TB. ULP-H's record included documentation of a negative TST on July 14, 2021; however, a second TST was not completed. ULP-H was hired on August 1, 2021, to provide direct care to residents under the assisted living with dementia care license. On September 29, 2021, at 1:45 p.m. RN-B confirmed ULP-F and ULP-H had not received a completed a second TST, as required. TB TRAINING RN-B RN-B's employee record lacked documentation of TB training at time of hire. On September 29, 2021, at 1:45 p.m. RN-B confirmed she had not completed TB training. ULP-F	0 660		

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0 660	Continued From page 35 ULP-F's employee record lacked documentation of TB training at time of hire. On September 29, 2021, at 1:45 p.m. LALD-A confirmed ULP-F had not completed TB training. The licensee's TB Prevention Control policy dated March 31, 2019, indicated the RN was responsible for establishing and maintaining the TB prevention and control program, including: establishment of an infection control team, completion of a written TB risk assessment, screening of staff for TB and education of staff regarding TB signs and symptoms, the infection control plan and other communicable diseases. In addition, the policy indicated staff would be screened for TB with a two-step TST or single interferon gamma release assay (IRGA) for M. tuberculosis. 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	0 680		

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0 680	Continued From page 36 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. 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: During the entrance conference on September 27, 2021, at approximately 10:55 a.m., a request	0 680		

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0 680	Continued From page 37 was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. On September 27, 2021, at approximately 11:40 a.m. a facility tour was conducted with licensed assisted living director (LALD)-A. The facility's layout included three units. There was no observed signage posted or information regarding the licensee's emergency preparedness plan in any of the three units, main entrance, or elsewhere in the facility. In addition, there was no emergency exit diagrams posted on the second floor of the Aspen unit. The licensee's emergency preparedness plan included emergency plans for an active shooter outside and inside the facility, a fire plan, severe weather procedure, and a procedure for tornado. The licensee's plan lacked the following content and/or policies and procedures to address: - an all hazards approach risk assessment specific to the geographic location of the facility; - a comprehensive program to include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the development of arrangements with other facilities and providers to receive residents if needed; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of	0 680		

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0 680	Continued From page 38 residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families On September 29, 2021, at approximately 2:00 p.m., LALD-A confirmed they were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD-A verified they had not fully developed and implemented the	0 680		

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0 680	Continued From page 39 facility's emergency preparedness plan/program. The licensee's Plans for Natural Disasters and Emergencies policy dated April 23, 2019, indicated the provider was responsible for the development of the facility's written plan of action to address the resident's care and services in response to a natural disaster or other type of emergency that may affect the ability to provide services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing 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	0 730		

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0 730	Continued From page 40 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of services had been provided as identified in the service plan for four of four residents (R1, R2, R3 and R4) 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	0 730		

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0 730	Continued From page 41 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, R2, R3 and R4's records lacked documentation of services provided by staff. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing. On September 28, 2021, at approximately 6:45 a.m. unlicensed personnel (ULP)-H was observed to administer R1's morning medication. R1's service record for September 2021 included, but was not limited to, the following scheduled services: dressing, grooming/oral hygiene, toileting, and spot cleaning every shift. R1's record lacked the following documentation for September 1-27, 2021: - 63 of 81 scheduled services for dressing; - 63 of 81 scheduled services for grooming/oral hygiene; - 63 of 81 scheduled services for toilet use; - 66 of 81 scheduled services for spot cleaning; - 63 of 81 scheduled services for respiratory infection monitoring; and - 4 of 4 laundry and bed linen services On September 29, 2021, at approximately 12:17 p.m. registered nurse (RN-B) and licensed assisted living director (LALD)-A stated they believed the above noted scheduled services	0 730		

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0 730	Continued From page 42 were provided; however, they were not documented. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, toileting. On September 28, 2021, at approximately 8:10 a.m. ULP-I was observed to assist R2 with dressing, grooming and toileting. R2's service record for September 2021 included, but was not limited to, the following services scheduled: bathing, dressing, toilet use, spot cleaning, linen's/bedding, personal laundry. R2's record lacked the following documentation for September 1-28, 2021: - 2 out of 4 scheduled services for bathing; - 18 out of 56 scheduled services for dressing/undressing; - 44 out of 84 scheduled services for toileting; - 44 out of 84 scheduled services for spot cleaning; - 5 out of 8 scheduled services for linen's/bedding; - 5 out of 8 scheduled services for personal laundry; and - 52 of 84 scheduled services for temperature monitoring and oxygen saturation monitoring On September 29, 2021, at approximately 1:00 p.m. RN-B and LALD-A stated they believed the above noted scheduled services were provided; however, they were not documented. R3	0 730		

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0 730	Continued From page 43 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m. ULP-F was observed to provide personal hygiene cares to R3. R3's service record for September 2021 included, but was not limited to, the following scheduled services: dressing, personal hygiene, toilet use, transfers, empty leg bag and record output, temperature and oxygen monitoring every shift, linens and bedding weekly, personal laundry weekly, deep clean weekly, bathing weekly, skin assessment weekly, vital signs weekly, weights weekly and safety checks, repositioning, catheter cares and incontinence management every two hours. R3's record lacked the following documentation for September 1-28, 2021: - 27 of 56 scheduled services for dressing; - 25 of 56 scheduled services for personal hygiene; - 23 of 56 scheduled services for toilet use; - 27 of 56 scheduled services for transfers; - 55 of 84 scheduled services for emptying leg bag and recording output; - 192 of 336 seceded services for safety checks, repositioning, catheter cares, and incontinence management every two hours; - 74 of 84 scheduled services for temperature monitoring and oxygen saturation monitoring; and	0 730		

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0 730	Continued From page 44 - 4 of 4 scheduled services for linens and bedding, personal laundry, deep cleaning, bathing, weekly skin assessment, vital signs and weights. On September 29, 2021, at 12:45 p.m. LALD-A and RN-B confirmed R3's record lacked complete documentation. LALD-A stated R3 frequently refused services. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50 a.m. ULP-E was observed to provide medication administration to R4. R4's service record for September 2021 included, but was not limited to, the following scheduled services: temperature and oxygen saturation monitoring every shift, linens and bedding weekly, personal laundry weekly, deep cleaning weekly, vital signs and weight weekly and skin assessment weekly. R4's record lacked the following documentation for September 1-28, 2021: - 77 of 84 scheduled services for temperature and oxygen saturation monitoring; and - 3 of 4 scheduled services for linens and bedding, personal laundry, deep cleaning, vital signs and weight and skin assessment. On September 29, 2021, at approximately 1:00	0 730		

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0 730	Continued From page 45 p.m. LALD-A confirmed R4's record lacked complete documentation. The licensee's Content of Client Records policy revised November 23, 2020, indicated the record would include documentation that services had been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 46 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a sufficient number of smoke alarms outside resident sleeping areas in the Birches and Oaks buildings. This had the potential to directly affect all residents, staff and visitors in those buildings. 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 resdient's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: On September 28, 2021, between 11:30 a.m. and 3:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A and maintenance-L. Observations of only one smoke alarm was installed in each hallway outside resident sleeping rooms in the Birches and Oaks buildings. LALD-A confirmed the facility did not have additional smoke alarms installed within those hallways. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 47 (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 facility failed to ensure a smoking shed was maintained 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 had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 28, 2021, at approximately 2:30 p.m. survey staff toured the smoking shed with maintenance-L. The following observations were made during the tour: - smoking shed was constructed of combustible materials (plywood, oriented strand board, wood wall and ceiling studs, kraft-faced insulation) and	0 800		

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0 800	Continued From page 48 ashes were noted on the floor of the shed; - interior surfaces of shed were unfinished and combustible materials were exposed; - an open exposed ash tray contained burned cigarette butts; - shed was provided with a door that when shut, completely enclosed the shed; - the door used to exit the Aspen building to access the smoking shed was a dining room fire exit door; - a walkway was provided with handrails that led from the fire exit door directly to the smoking shed, the walkway ends at the smoking shed; and - no prevention measures were observed to prevent a fire originating in the shed from spreading to the adjacent buildings. On September 28, 2021, at approximately 3:30 p.m. during the exit interview, licensed assisted living director (LALD)-A confirmed the smoking shed was used by assisted living residents for smoking and was unsure if the structure met code. No information was provided to confirm: - shed was permitted and approved by local building official; - shed was constructed and finished to code; and - shed was reviewed with local fire code official. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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	0 900		

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0 900	Continued From page 49 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 contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for	0 900		

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0 900	Continued From page 50 four of four residents (R3, R4, 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 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: R3, R4, R1 and R2's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (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 In addition, the resident records lacked evidence the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - 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; and - the facility must offer the resident the opportunity to identify a designated representative.	0 900		

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0 900	Continued From page 51 R3 R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m. unlicensed personnel (ULP)-F was observed to provide personal hygiene cares to R3. R4 R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. R1 R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing. On September 28, 2021, at approximately 6:45 a.m. ULP-H was observed to administer R1's morning medication. R2	0 900		

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0 900	Continued From page 52 R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, toileting. On September 28, 2021, at approximately 7:45 a.m. ULP-H was observed to administer R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. On September 29, 2021, at approximately 11:55 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed a contract had not been developed or executed for any of the licensee's current residents as required. The licensee lacked a policy regarding the development and execution of a contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 53 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer four of four residents (R3, R4, R1 and R2) the opportunity to identify a designated representative 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:	0 950		

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0 950	Continued From page 54 R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received services which	0 950		

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0 950	Continued From page 55 included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. On September 29, 2021, at approximately 12:06 p.m., licensed assisted living director (LALD)-A confirmed R4, R3, R1 and R2, and all other residents at the facility had not been provided the opportunity to identify a designated representative. Thus, all the resident records lacked the notice of identifying a designated representative with the required statutory language, or the documentation they had declined to name a designated representative. The licensee lacked a designated representative policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01310 SS=D	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses	01310		

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01310	Continued From page 56 providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure correct authentication with name and title of the person making the entry for one of four employees (unlicensed personnel (ULP)-F) 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: ULP-F's electronic signature did not reflect the correct title for the position worked. On September 28, 2021, at 8:35 a.m. ULP-F was observed providing personal hygiene cares to R3 and preparing R3's medications for administration via feeding tube.	01310		

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01310	Continued From page 57 R3's Progress Notes included 61 entries from August 30, 2021, to September 28, 2021, electronically signed by ULP-F. ULP-F's electronic signature indicated her title was Licensed Practical Nurse (LPN). On September 29, 2021, at 1:45 p.m., licensed assisted living director (LALD)-A confirmed ULP-F was not a LPN and her title had been inadvertently entered incorrectly by a prior employee. The licensee's Documentation of Medication Management Services policy revised on November 23, 2020, indicated documentation would be authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01460		

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01460	Continued From page 58 review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for four of four employees (registered nurse (RN)-B, licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-F, and ULP-H) 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: RN-B, LPN-C, ULP-F and ULP-H were hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license. On September 28, 2021, at approximately 6:45 a.m., ULP-H was observed to administer R1's morning medication. On September 28, 2021, at 8:35 a.m., ULP-F was observed to provide personal hygiene cares for R3. RN-B, LPN-C, ULP-F and ULP-H's employee records did not contain documentation of completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On September 29, 2021, at approximately 1:45 p.m., licensed assisted living director (LALD)-A confirmed orientation to assisted living facility licensing requirements and regulations had not been provided to any of the facility's staff. The licensee lacked a policy outlining the content	01460		

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01460	Continued From page 59 for orientation to assisted living facility requirements and regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure four of four employees (registered nurse (RN)-B, licensed practical nurse (LPN)-C, unlicensed personal (ULP)-E and ULP-H) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a	01540		

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01540	Continued From page 60	01540		

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:

The licensee had a current assisted living facility with dementia care license.
RN-B, LPN-C, ULP-F and ULP-H were hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license.
On September 28, 2021, at approximately 6:45 a.m., ULP-H was observed to administer R1's morning medication.
On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed providing personal hygiene care to R3.
RN-B, LPN-C, ULP-F and ULP-H's employee records did not contain documentation of the required eight (8) hours of training on the specific dementia care topics within 80 working hours of their respective hire dates.
On September 29, 2021, at approximately 1:45 p.m., RN-B confirmed she had not completed the above noted dementia training as required.
On September 29, 2021, at approximately 1:45 p.m., licensed assisted living director (LALD)-A confirmed ULP-F did not complete the above noted dementia training as required, despite having "chased her down."
On September 29, 2021, at approximately 1:50 p.m., LALD-A and RN-B confirmed LPN-C and ULP-H had not completed the above noted

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01540	Continued From page 61 dementia training as required. The licensee's Dementia Training and Disclosure Requirements (for agencies that are part of a specialized memory care program) policy revised Nonmember 23, 2020, indicated dementia training was required for all direct care staff and their supervisors; however, the policy lacked the specific time frame in which the training would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01620 SS=F	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	01620		

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01620	Continued From page 62 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14 day reassessment for one of one resident (R2). In addition, the licensee failed to ensure the RN completed a reassessment not to exceed 90 days for three of three residents (R1, R3 and R4) 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: During the entrance conference on September 27, 2021, at approximately 10:30 a.m,. registered nurse (RN)-B confirmed she completed a pre-admission assessment, a 14 day assessment, an assessment at least once a month and with any change of condition. 14 DAY ASSESSMENT R2 R2's record lacked evidence of a 14-day reassessment was completed by the RN. R2 started to receive services July 13, 2021. R2's diagnoses included, but were not limited to,	01620		

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01620	Continued From page 63 anxiety, hypertension (high blood pressure), atrial fibrillation (an irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming and toileting. On September 28, 2021, at approximately 7:45 a.m., unlicensed personnel (ULP)-H was observed to administer R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. R2's record lacked evidence a 14-day reassessment was completed after the initiation of services. 90 DAY ASSESSMENT R1 R1's record lacked evidence of an assessment completed by the RN in the past 90 days. R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation, and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing.	01620		

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01620	Continued From page 64 On September 28, 2021, at approximately 6:45 a.m., ULP-H was observed to administer R1's morning medication. R1's record lacked evidence of any assessments. R3 R3's record lacked evidence of an assessment completed by the RN in the past 90 days. R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3. R3's record lacked evidence of any assessments. R4 R4's record lacked evidence of an assessment completed by the RN in the past 90 days. R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and	01620		

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	30361	A. BUILDING: _____ B. WING _____	09/30/2021

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01620	Continued From page 65 Parkinson's disease. R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. R4's record lacked evidence of any assessments. On September 29, 2021, at 12:00 p.m., RN-B confirmed she had not completed any assessments for any of the facility's current residents. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated November 23, 2020, indicated nursing assessments would be completed according to the the Comprehensive Home Care Laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	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 66 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 four of four residents' (R1, R2, R3 and R4) service plans were developed and implemented 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: R1, R2, R3, and R4's record lacked evidence that a service plan had been developed.	01640		

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01640	Continued From page 67 R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's "care plan" last revised February 2, 2019, indicated the resident received services which included medication administration, blood glucose (sugar) monitoring, wound care, housekeeping, laundry, and assistance with bathing. On September 28, 2021, at approximately 6:45 a.m. unlicensed personnel (ULP)-H was observed to administer R1's morning medication. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed to administer R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease)	01640		

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01640	Continued From page 68 and nicotine dependence. R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. On September 29, 2021, at approximately 12:17 p.m., registered nurse (RN)-B and licensed assisted living director (LALD)-A verified R1, R2, R3, R4, and all residents receiving services under the facility's license did not have a service plan developed and implemented as required. The licensee's Development and Revision of the	01640		

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01640	Continued From page 69 Service Plan dated November 27, 2020, noted after completion of a full individualized initial assessment, an initial service plan would be established. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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 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,	01700		

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01700	Continued From page 70 theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for four of four residents (R1, R2, R3 and R4) 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: During the entrance conference on September 27, 2021, at approximately 10:40 a.m., licensed assisted living director (LALD)-A and RN-B confirmed the licensee provided medication management services to the majority of residents at the facility. R1, R2, R3, and R4's record lacked evidence the RN conducted a face-to-face review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the residents' records failed to identify interventions needed in the management of medications to prevent diversion of medications	01700		

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01700	Continued From page 71 by the resident or others who may have access to the medications. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received medication management services. R1's prescriber's orders dated September 22, 2021, included but were not limited to, the following medications: one mild pain reliever, two medications to treat an irregular heart rate, one blood thinner, one thyroid replacement hormone, one medication to treat nerve pain, one steroid, one medication to treat heartburn, one bronchodilator inhaler and one vitamin. On September 28, 2021, at approximately 6:45 a.m., unlicensed personnel (ULP)-H was observed to administer R1's morning medication. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021,	01700		

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01700	Continued From page 72 included but were not limited to, the following medications: one blood thinner, one antianxiety medication, one antiemetic, one stool softener, one medication to treat an irregular heart rhythm, one mild pain reliever, and one medication to treat moderate to severe pain. On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed to administer R2's morning medications. R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. R3's record lacked prescriber orders for medications. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021,	01700		

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01700	Continued From page 73 indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. R4's prescriber's orders dated September 27, 2021, included but were not limited to, the following medications: two anti-hypertensives, one blood thinner, one psychotropic, two supplements, two Parkinson's disease medications, one antianxiety medication, one stool softener, one acid reflux reducer, one mild pain reliever, one diabetic medication, one thyroid medication, two sleep aides, and one medication for urinary retention. On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. R1, R2, R3, and R4's records lacked evidence the RN conducted a face-to-face review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the residents' records failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On September 29, 2021, at approximately 12:09 p.m., RN-B confirmed a face-to-face medication management assessment had not been completed for R1, R2, R3, R4, and all other residents at the facility who received medication management services, to include all the required content as noted above.	01700		

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01700	Continued From page 74 The licensee's Initial and On-going Nursing Assessment of Clients policy dated November 23, 2020, noted an assessment of the resident's need for medication management services would be completed face-to-face and would include: identification and review of all medications the resident was known to be taking; indications for medications; side effects; contraindications; allergic or adverse reactions and actions to address these issues and; interventions needed to prevent diversion of the medications by the resident or by others who may have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	01730		

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01730	Continued From page 75 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. (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 and maintain a current individualized medication management record for each resident to include all required content for four for four residents (R1, R2, R3 and R4) 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	01730		

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01730	Continued From page 76 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 27, 2021, at approximately 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to the majority of residents at the facility. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received medication management services. R1's prescriber's orders dated September 22, 2021, included but was not limited to, the following medications: a mild pain reliever, two medications to treat an irregular heart rate, one blood thinner, one thyroid replacement hormone, one medication to treat nerve pain, one steroid, one medication to treat heartburn, one bronchodilator inhaler and one vitamin. On September 28, 2021, at approximately 6:45 a.m., unlicensed personnel (ULP)-H was observed to administer R1's morning medication. R1 lacked a service plan to include a written	01730		

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01730	Continued From page 77 statement of the medication management services the resident was provided. In addition, R1's medication record did not include an annual review of the resident's medication management plan to include all the required content. On September 29, 2021, at approximately 12:10 p.m., RN-B confirmed R1's medication management plan had not been reviewed annually and did not include all the required content. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021, included but were not limited to, the following medications: one blood thinner, one antianxiety medication, one antiemetic, one stool softener, one medication to treat an irregular heart rhythm, one mild pain reliever, and one medication to treat moderate to severe pain. On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed to administer R2's morning medications. R2 lacked a service plan to include a written statement of the medication management services the resident was provided. In addition, R2's medication management record did not include the following: - a description of storage of medications based	01730		

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01730	Continued From page 78	01730		

on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions;
- documentation of specific resident instructions relating to the administration of medications;
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
- identification of medication management tasks that may be delegated to ULP;
- procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services;
- any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
- completion of medication reconciliation.

On September 29, 2021, at approximately 12:54 p.m., RN-B confirmed R2 did not have a medication management plan to include the above noted content as required.

R3
R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence.

R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene,

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ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

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01730	Continued From page 79 toileting/incontinence management, housekeeping and laundry. R3's record lacked prescriber orders for medications. R3 lacked a service plan to include a written statement of the medication management services the resident received. In addition, R3's medication management record did not include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions, - documentation of specific resident instructions relating to the administration of medications, - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, - identification of medication management tasks that may be delegated to ULP, - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services, - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions, and - completion of medication reconciliation. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease.	01730		

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01730	Continued From page 80 R4's record lacked a service plan; however, R4's "care plan" last revised September 11, 2021, indicated the resident received services which included medication administration, catheter management, bathing reminders, housekeeping and laundry. R4's prescriber's orders dated September 27, 2021, included but were not limited to, two anti-hypertensives, one blood thinner, one psychotropic, two supplements, two Parkinson's disease medications, one antianxiety medication, one stool softener, one acid reflux reducer, one mild pain reliever, one diabetic medication, one thyroid medication, two sleep aides, and one medication for urinary retention. On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. R4 lacked a service plan to include a written statement of the medication management services the resident received. In addition, R4's medication management record did not include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to ULP; - procedures for staff notifying a RN or appropriate licensed health professional when a	01730		

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01730	Continued From page 81 problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record dated November 23, 2020, noted the RN would develop an individualized medication management plan for each resident that needs or requests medication management services. The RN would ensure that each Individualized Medication Management Plan was kept up-to-date and consistent with prescriber's orders and with the needs and preferences of the resident. 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: (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	01750		

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01750	Continued From page 82 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 observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-F) demonstrated competency for administering medication via feeding tube. In addition, the registered nurse (RN) failed to specify, in writing, specific instructions for one of one resident (R3) for administration of medications via feeding tube. 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: ULP-F ULP-F's employee record lacked documentation ULP-F had been trained and demonstrated competency in administering medications via feeding tube. ULP-F was hired on August 1, 2021, to provide direct care services to residents of the assisted living facility with dementia care. On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to prepare R3's medications for administration via feeding tube. R3 refused to allow the surveyor to observe the medication administration; however, ULP-F was able to verbalize how she would administer the medications to R3. ULP-F stated she had	01750		

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01750	Continued From page 83 learned the technique through her trained medication aide (TMA) class. On September 29, 2021, at 1:45 p.m., licensed practical nurse (LPN)-C stated she believed ULP-F was trained at the facility for administration of medications via feeding tube; however, LPN-C was unable to provide documentation of training and competency. R3 R3's record lacked specific written instructions, related to administering medications via feeding tube. R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration. R3's record lacked prescriber orders; however, R3's September 1 through September 27, 2021 medication administration record (MAR) indicated the following medications had been administered as scheduled: cholecalciferol 2000 units daily, no indication for use provided; gabapentin 1200 mg at bedtime, no indication for use provided; multivitamin 1 tablet daily for supplementation; polyethylene glycol 3350 Kit, 17 grams in 8 ounces of liquid daily, no indication for use provided; sennosides 8.6 mg, 2 tablets daily, no indication for use provided; Eliquis 5 mg twice daily for blood clot prevention; gabapentin 600 mg in morning and afternoon, no indication for use provided; Nystop powder 100,000 units/grams (gr) topically twice daily for skin infection;	01750		

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01750	Continued From page 84	01750		

omeprazole 2 mg/ml twice daily for indigestion; oyster shell calcium 500 mg twice daily, no indication for use provided; baclofen 20 mg four times a day, no indicication for use provided; acetaminophen 650 mg every 6 hours as needed (PRN) for pain; hydrocortisone cream 1% topically PRN for itching; Immodium A-D 2 mg PRN for loose stools; lanolin ointment 30% topically PRN for skin protection; Phenazopyridine HCL 200 mg PRN three times a day for pain; and Zinc Oxide Paste 40% topically PRN for skin irritation. In addition, the MAR lacked instructions for how much water should be used to flush the feeding tube throughout medication administration.

On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3 and to prepare R3's medications for administration via feeding tube. The medications included: cholecalciferol 2000 units; multivitamin tablet; polyethylene glycol 17 gr; sennosides 8.6 mg; acetaminophen 650 mg; Eliquis 5 mg; gabapentin 600 mg; oyster shell calcium 500 mg; and baclofen 20 mg. All medications were crushed and dissolved in a small amount of water for administration via feeding tube.

On September 29, 2021, at approximately 12:45 p.m., RN-B confirmed R3's record lacked instructions specific to administering R3's medications via feeding tube.

The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated November 23, 2020, indicated the RN may delegate medication administration to ULP only after the RN had:
-instructed the licensed personnel in the proper

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01750	Continued From page 85 methods to administer the medications, and the ULP had demonstrated the ability to competently follow the procedures; -developed specific written instructions for each resident and documented those instructions in the resident's MAR; and -communicated with the ULP about the individual need of the resident. 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 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 observation, interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R16) with records reviewed. In addition, the licensee failed	01760		

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01760	Continued From page 86 to ensure medications were transcribed as prescribed for one of nine residents (R18) 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: FOLLOWING MANUFACTURER'S INSTRUCTIONS R16 R16's Advair Diskus 250-50 micrograms (mcg) (bronchodilator) was not administered according to manufacturer's instructions. R16's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD - chronic obstruction of lung airflow that interferes with normal breathing), hypertension (high blood pressure), and dementia. R16's record lacked a service plan; however, R16's medication administration record (MAR) dated September 1 through September 27, 2021, indicated the resident received medication management services to include medication administration four times a day. R16's prescriber orders dated April 13, 2021, included an order for Advair Diskus 250-50 mcg to be administered twice daily, and to have the resident rinse her mouth out after use.	01760		

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01760	Continued From page 87 On September 28, 2021, at approximately 9:35 a.m., unlicensed personnel (ULP)-G was observed to conduct a medication pass for R16 which included administration of the Advair Diskus inhaler. ULP-G activated the inhaler; handed the inhaler to R16; the resident released one puff of the inhaler into her mouth and took a long, fast breath in; R16 handed the inhaler back to ULP-G. ULP-G did not instruct the resident to rinse her mouth out after the administration of the inhaler. ULP-G proceeded to administer R16's oral medications which the resident took with sips of water. On September 28, 2021, at approximately 9:45 a.m. immediately following the above medication pass observation, ULP-G confirmed she had not instructed R16 to rinse her mouth out following administration of the Advair Diskus inhaler. ULP-G stated she was unaware this should be done; however, ULP-G confirmed the directions on the label attached to the Advair Diskus provided instructions to rinse mouth out after use. On September 28, 2021, at approximately 9:55 a.m., licensed practical nurse (LPN)-C confirmed the manufacturer's instructions for inhaler administration should be followed, and R16 should have rinsed her mouth out after administration of her Advair Diskus inhaler. The manufacturer's instructions for use of the Advair Diskus inhaler dated August 2020, indicated the resident should rinse their mouth with water after use and spit the water out. Do not swallow the water. TRANSCRIPTION ERROR	01760		

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01760	Continued From page 88 R18 R18's diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, dementia, and traumatic brain injury (TBI). R18's record lacked a service plan; however, R18's MAR dated September 1 through September 27, 2021, indicated the resident received medication management services to include medication administration three times a day. R18's prescriber orders dated August 9, 2021, included an order for ibuprofen 800 mg by mouth daily. On September 28, 2021, at 6:50 a.m., ULP-E was observed to administer R18's morning medications, which included ibuprofen 800 mg; however, R18's MAR indicated the order was ibuprofen 400 mg by mouth every morning and every bedtime. On September 29, 2021, at approximately 1:15 p.m., RN-B confirmed R18's ibuprofen order was not transcribed correctly onto the MAR. The licensee's Documentation of Medication Services on the MAR policy dated November 23, 2020, noted the staff would administer medications according to the instructions on the MAR. The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders policy dated November 23, 2020, noted upon receipt of a prescription or order, the RN would take action to implement the order, including updating the MAR or other documents as necessary to reflect any changes in prescriptions	01760		

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01760	Continued From page 89 or orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document all required content for medication set up for one of two residents (R2) 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 documentation by the licensed nurse at the time of medication setup to include the documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of	01770		

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01770	Continued From page 90 administration, and name of person completing medication setup. R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation (an irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021, included an order for morphine (a moderate to severe pain reliever) 4 milligrams (mg) to be administered buccally (in the cheek area of the mouth) every four hours scheduled for pain and 2 mg buccally every one hour as needed for pain/dyspnea (shortness of breath). On September 28, 2021, at approximately 7:45 a.m., unlicensed personnel (ULP)-H was observed to administer R2's morning medications which included two prefilled syringes of morphine 0.1 milliliters (ml) [equivalent to 4 mg of morphine]. ULP-H stated the nurse setup R2's prefilled morphine syringes. R2's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup. On September 29, 2021, at approximately 1:05 p.m., registered nurse (RN)-B verified R2's medication setup for the resident's morphine was	01770		

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01770	Continued From page 91 not documented in the resident's record to include the required content noted above. The licensee's Documentation of Medication Management Services dated November 23, 2020, noted the RN or LPN would document each medication as it was setup. The documentation would include the date of the medication setup, name of the medication, quantity of dose, dates and times the medication was to be administered, route of administration, any specific directions, and the name and title of the person doing the medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 92 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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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
01790	Continued From page 93 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available; and failed to provide complete documentation of medications sent with one of one resident (R1) who had an unplanned time away. In addition, the licensee failed to ensure two of two unlicensed personnel (ULP-F and ULP-H) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 27, 2021, at approximately 10:40 a.m., licensed assisted living director (LALD)-A and RN-B confirmed the licensee provided medication management services to the majority of residents at the facility. On September 29, 2021, at approximately 11:50 a.m., RN-B confirmed the ULP would prepare and send medications with the residents for unplanned times away.	01790		

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01790	Continued From page 94 UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP The licensee failed to develop and implement a written procedure for the ULP providing medications for residents having unplanned times away. The licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy dated November 23, 2020, indicated for situations when there would be a short-term absence that was not known in advance and a licensed nurse was not available, the RN may delegate this task to ULP. The RN would develop written procedures for the ULP to follow. The licensee's policy lacked the written procedure to include: - the resident must be provided written information on medications, including any specific instructions for administering or handling the medications, including controlled substances; - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; and - how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative. On September 29, 2021, at approximately 1:40 p.m., RN-B confirmed the licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy did not	01790		

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01790	Continued From page 95 include the above noted written procedure as required. DOCUMENTATION FOR UNPLANNED TIME AWAY R1's record lacked written information on medications, including any special instructions for administering or handling the medications when the resident was away from the facility during a scheduled medication administration time. R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received medication management services. R1's prescriber's orders dated September 22, 2021, included but were not limited to, the following medications: a mild pain reliever, two medications to treat an irregular heart rate, one blood thinner, one thyroid replacement hormone, one medication to treat nerve pain, one steroid, one medication to treat heartburn, one bronchodilator inhaler and one vitamin. The "communication book" for R1 indicated the resident was out of the facility on September 18, 2021, and September 25 through 27, 2021. R1's record lacked documentation of the medications provided to the resident or the resident's designated representative to include who received the medications, the person who	01790		

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provided the medications to the resident, the name and quantity of the medications provided, if any unused medications were returned, and a review by the RN to verify that the procedure was followed and the documentation completed for the above noted times away from home.

On September 29, 2021, at approximately 11:50 a.m., RN-B confirmed the above noted times away for R1 were unplanned, and the medications had been provided by the ULP. RN-B stated ULP usually just send her bag of medication bottles with the resident and family. RN-B verified R1's record lacked the required documentation for when medications are provided to R1 for the residents unplanned times away. RN-B also confirmed there was no documentation upon R1's return to assure the unplanned time away procedure had been followed and the documentation of any unused medications returned.

TRAINING AND COMPETENCY EVALUATIONS

ULP F
ULP-F was hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license to include medication administration.

On September 28, 2021, at 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3 and prepare medications for administration via feeding tube.

ULP-F's record lacked evidence to indicate ULP-F had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from

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01790	Continued From page 97 home. ULP-H ULP-H was hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license to include medication administration. On September 28, 2021, at approximately 6:45 a.m., ULP-H was observed to administer R1's morning medication. ULP-H's record lacked evidence to indicate ULP-H had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On September 29, 2021, at approximately 1:45 p.m., RN-B and licensed assisted living director (LALD)-A confirmed ULP-F, ULP-H, and all other ULP at the facility, had not been trained or demonstrated competency to provide medications for residents having unplanned times away. The licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy dated November 23, 2020, noted for unplanned times away from home the RN may delegate this task ULP if the RN had trained the ULP and determined the ULP to be competent to follow the procedures for providing medications to residents. In addition, when medications were provided to the resident or the resident's designated representative for unplanned time away the process must be documented in the resident record to include the name of the person that received the medications, the time and date the medications	01790		

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01790	Continued From page 98 were provided to the resident, which medications were provided and the amount of medications provided, and the name and title of the ULP who provided the medications to the resident or the resident's designated representative. Also, medications that went with a resident during an absence and were not used would be appropriately documented by the receiving staff including the medication name, quantity, and reason returned. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of nine residents (R3) 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	01820		

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01820	Continued From page 99	01820		

a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R3's record lacked prescriber's orders for any of the medications administered by the licensee.
R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence.
R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration.
R3's record lacked prescriber orders; however, R3's September 1 through September 27, 2021, medication administration record (MAR) indicated the following medications had been administered as scheduled: cholecalciferol 2000 units daily, no indication for use provided; gabapentin 1200 mg at bedtime, no indication for use provided; multivitamin 1 tablet daily for supplementation; polyethylene glycol 3350 Kit, 17 grams in 8 ounces of liquid daily, no indication for use provided; sennosides 8.6 mg, 2 tablets daily, no indication for use provided; Eliquis 5 mg twice daily for blood clot prevention; gabapentin 600 mg in morning and afternoon, no indication for use provided; Nystop powder 100,000 units/grams (gr) topically twice daily for skin infection; omeprazole 2 mg/ml twice daily for indigestion; oyster shell calcium 500 mg twice daily, no indication for use provided; baclofen 20 mg four times a day, no indicication for use provided; acetaminophen 650 mg every 6 hours as needed (PRN) for pain; hydrocortisone cream 1% topically PRN for itching; Immodium A-D 2 mg PRN for loose stools; lanolin ointment 30% topically PRN for skin protection; Phenazopyridine HCL 200 mg PRN three times a day for pain; and Zinc Oxide Paste 40% topically

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01820	Continued From page 100 PRN for skin irritation. On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3 and to prepare R3's medications for administration via feeding tube. The medications included: cholecalciferol 2000 units; multivitamin tablet; polyethylene glycol 17 gr; sennosides 8.6 mg; acetaminophen 650 mg; Eliquis 5 mg; gabapentin 600 mg; oyster shell calcium 500 mg; and baclofen 20 mg. On September 29, 2021, at approximately 12:45 p.m., registered nurse (RN)-B confirmed R3's record lacked prescriber orders for the above listed medications. RN-B stated she had "gone around and around for orders" with R3's prescriber; however, RN-B was unable to provide documentation of any attempts to contact the prescriber. The licensee's Requesting and Receiving Medication Prescriptions, Refills, and Treatment Orders policy dated November 23, 2020, indicated the RN was responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, to be managed by the licensee were kept in the resident's record. Furthermore, the policy noted the RN or LPN would document communications with the prescriber(s) in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880		

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01880	Continued From page 101 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 manufacturer's instructions for two of two medication refrigerators (Aspen and Oaks). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 27, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the licensee provided medication management services to the licensee's residents, including storage of medication. MEDICATION REFRIGERATOR MONITORING The licensee failed to monitor the Aspen and Oaks medication refrigerators to ensure medications were stored according to manufacturer's instructions. Aspen Refrigerator On September 27, 2021, at approximately 11:15 a.m., the refrigerator in the Aspen medication	01880		

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01880	Continued From page 102 room was observed with licensed practical nurse (LPN)-C. LPN-C confirmed the refrigerator temperature to be 39 degrees Fahrenheit (F) and confirmed the refrigerator lacked daily monitoring of temperature. LPN-C stated the refrigerators used to have temperature logs. The refrigerator contained: - nine unopened Novolog 70/30 insulin Flexpen (a multiple dose pen shaped injector device used for insulin administration); -one unopened Victoza pen (antidiabetic medication); -nine unopened Novolog (short acting insulin) pens; and -13 unopened Lantus (long acting insulin) pens. The manufacturer's instructions for Novolog 70/30 insulin Flexpen dated April 28, 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog 70/30 to freeze. The manufacturer's instructions for Victoza dated December 2020 indicated before opening store Victoza pens in the refrigerator (36-46 degrees F). Do not allow Victoza to freeze. The manufacturer's instructions for Lantus insulin pens dated December 2019 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog dated June 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog to freeze. Oaks Refrigerator	01880		

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01880	Continued From page 103 On September 27, 2021, at approximately 11:30 a.m., the refrigerator in the Oaks mediation room was observed with LPN-C. LPN-C confirmed the refrigerator temperature was 40 degrees F, and confirmed the refrigerator lacked daily monitoring of temperature. The refrigerator contained: -17 pre-drawn oral syringes of Morphine Sulfate Concentrate. The manufacturer's instructions for Morphine Sulfate Concentrate dated June 21, 2021, indicated to store the solution at controlled room temperature, between 59 to 86 degrees F. The licensee's Storage of Medications policy last reviewed November 28, 2020, indicated the RN would identify where medications would be stored under proper temperature controls. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01890 SS=E	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 maintained bearing the original prescription	01890		

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01890	Continued From page 104 label with legible information including the expiration date for time sensitive medications for four of four residents (R9, R10, R16 and R17) 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: On September 27, 2021, at approximately 11:15 a.m. a tour of the facility was conducted with licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C, including review of the locked medication cabinets on the Aspen and Oaks units. The following was observed, and confirmed with LPN-C: ORIGINAL PRESCRIPTION LABELS R10 R10's opened Novolog (short acting insulin) 100 units and Lantus (long acting insulin) 100 unit/milliliter (ml) both lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. TIME SENSITIVE MEDICATIONS R9	01890		

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01890	Continued From page 105 R9's Azelastine 137 micrograms (mcg) (nasal spray) lacked a label which indicated the date the inhaler had been opened and when the inhaler would expire. R10 R10's opened Novolog 100 units and Lantus 100 unit/ml both lacked the date the pens had been opened and when the pens would expire. R16 R16's in use Advair Diskus 250-50 micrograms (mcg) (bronchodilator) lacked a date the inhaler had been removed from the foil packaging pouch and when the inhaler would expire. R17 R17's opened Victoza (helps control blood sugar) 18 mg/3 ml and Novolog 70/30 insulin pens both lacked the date the pens had been opened and when the pens would expire. The manufacturer's instructions for Azelastine nasal spray dated February 2019, directed to discard the inhaler after one year from first use or by expiration date on box, whichever was soonest. The manufacturer's instructions for Novolog 70/30 insulin flexpens dated April 28, 2021, directed to discard the insulin pen 14 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Advair Diskus inhaler dated August 2020, directed to discard the inhaler one month after opening the foil pouch. The manufacturer's instructions for Victoza dated December 2020, directed to discard the pen 30	01890		

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01890	Continued From page 106 days after it had been opened, even if it still had medication left in it. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Novolog dated June 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. On September 27, 2021, at approximately 11:15 a.m., LPN-C confirmed all medications should have original labels and be dated after opening with open date and expiration date. The licensee's Storage of Medications policy reviewed November 28, 2020, indicated a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. 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	01910		

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01910	Continued From page 107 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 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one deceased resident (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:	01910		

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01910	Continued From page 108 R5's record lacked documentation of medication disposition upon discharge. R5 expired on August 29, 2021, after receiving services for diagnoses including, but not limited to, heart failure, atrial fibrillation, osteoarthritis, depression and anxiety. R5's record lacked a service plan; however, R5's "care plan" last revised August 11, 2021, indicated the resident received services which included medication administration, bathing assistance, toileting, laundry and housekeeping. R5's prescriber orders dated August 26, 2021, included but were not limited to, the following medications: one liquid narcotic pain reliever, one antianxiety medication and one secretion reducing medication. R5's discharge summary dated August 29, 2021, did not include the disposition of the medications. R5's record lacked evidence of documentation of R5's disposition of 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. The licensee's Disposal or Destruction of Medication policy dated November 23, 2020, indicated prescription drugs managed and secured by the facility after death of a resident for whom the drug was prescribed must be destroyed by the RN or LPN with one other person as a witness. Documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs and signature of witness to the destruction must be recorded in the resident's record. On September 29, 2021, at 12:45 p.m., registered nurse (RN)-B confirmed the licensee's policy was not followed and R5's record lacked	01910		

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01910	Continued From page 109 documentation of disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01920 SS=D	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to follow the procedure for loss and spillage of a controlled substance for one of one resident (R2), who had a controlled substance managed by 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	01920		

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01920	Continued From page 110 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 diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation (irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021, included an order for morphine (a moderate to severe controlled substance pain reliever) 4 milligrams (mg) to be administered buccally (in the cheek area of the mouth) every four hours scheduled for pain, and 2 mg buccally every one hour as needed for pain/dyspnea (shortness of breath). On September 28, 2021, at approximately 7:45 a.m., unlicensed personnel (ULP)-H was observed to administer R2's scheduled morning medications which included two prefilled syringes of morphine 0.1 milliliters (ml) [equivalent to 4 mg of morphine]. ULP-H stated the nurse set up R2's prefilled morphine syringes. On September 28, 2021, at approximately 10:55 a.m., licensed practical nurse (LPN)-C confirmed she and registered nurse (RN)-B filled and set up the morphine syringes for R2. LPN-C stated the bottle of morphine was stored in the medication	01920		

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01920	Continued From page 111 refrigerator in the nursing office and not in the medication refrigerator on the unit. On September 28, 2021, at approximately 11:05 a.m. the locked medication refrigerator in the nursing office was reviewed with RN-B and LPN-C. RN-B verified there currently was 18 ml of morphine concentrate (20 mg/1 ml) in the bottle of morphine. The two (2) narcotic log forms for R2's morphine were reviewed and verified with RN-B with findings listed below: First narcotic log form - Entry dated September 8, 2021, noted there was 23 ml (equivalent to 460 mg) of morphine in the bottle; - Entry dated September 13, 2021, (no time) signed by RN-B (no dual/witnessed signature) read "found bottle had spilt in bag? 16 ml currently in bottle". (This resulted in 7 ml [equivalent to 140 mg] of morphine which was documented, but not witnessed, as being spilled.) - A second entry dated September 13, 2021, at 2:30 p.m. by RN-B indicated 5 ml of morphine had been drawn up into syringes, leaving an amount of 8 ml in the bottle (according to the narcotic log, there should be 11 ml left in the bottle after the morphine was drawn up into the syringes - not the 8 ml as indicated on the narcotic log form). This was the last entry on the narcotic log form, leaving 11 ml of morphine unaccounted for (equivalent 220 mg). Second narcotic log form The second narcotic log form for R2's morphine had entries dated September 19, 2021, thru September 28, 2021. - Entry dated September 19, 2021, noted a new bottle of 30 ml of morphine was on hand and 4 ml were drawn up into syringes, leaving a new	01920		

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01920	Continued From page 112 amount of 26 ml of morphine; - Entry dated September 24, 2021, noted 4 ml of morphine was drawn up into syringes, leaving a new amount of 22 ml; - Entry dated September 28, 2021, noted 4 ml of morphine 4 ml was drawn up into syringes, leaving a remaining amount of 18 ml (which was the current amount in the bottle). On September 28, 2021, at approximately 11:10 a.m., RN-B stated the licensee's policy was for two staff members to count the narcotics at the end of each shift. RN-B confirmed R2's Morphine was not being counted by two staff members at the end of each shift. RN-B verified the loss and/or spillage of R2's morphine as noted above had not been investigated. The licensee's Controlled Substances/Schedule II Drugs policy dated November 23, 2020, noted staff would count controlled drugs at the end of each shift. The staff person coming on duty and the staff person going off duty would count the controlled medications together and would document and report any discrepancies immediately to the RN. When a loss of spillage of a scheduled II drug occurs, an explanatory notation must be made in the resident's record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observed the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill. Whenever possible the witness should be a licensed nurse. The RN would document the destruction of any contaminated controlled substance. If a controlled drug is missing, the RN working with the manager would investigate and try to determine when the drugs went missing and who may have been involved.	01920		

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01920	Continued From page 113 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01940 SS=D	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 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.	01940		

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01940	Continued From page 114 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content for two of three residents (R1, R3) 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: During the entrance conference on September 27, 2021, at approximately 11:15 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R1 R1's record lacked evidence of a written statement on the resident's service plan for the services being provided to include blood glucose (sugar) monitoring. R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's "care plan" and Treatment or Therapy Plan last revised February 2, 2019, and April 25, 2019, respectively indicated the resident received blood glucose (sugar) checks twice a day as ordered by the prescriber.	01940		

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01940	Continued From page 115 R1's prescriber orders dated September 22, 2021, included an order for blood glucose checks two (2) times a day twice weekly. R1's documented services from August 1, 2021, through September 28, 2021, directed for blood glucose checks to be completed two times a day twice a week (on Tuesdays and Thursdays). R1's record indicated blood glucose checks had been completed five (5) times during this time frame with results ranging from 97 to 128 milligrams (mg)/deciliter (dL). R1's record lacked a service plan, thus lacked a written statement of the treatment services the resident received to include blood glucose monitoring. On September 29, 2021, at approximately 12:16 p.m. RN-B confirmed R1 did not have a service plan which included a written statement of treatment services provided for R1. R3 R3's record lacked evidence of a written statement on the resident's service plan for the services being provided to include Prevalon boots (relieves pressure), tube feeding, and daily range of motion stretches. R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management,	01940		

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01940	Continued From page 116 housekeeping and laundry. The "care plan" did not include a written statement of the treatment services the resident received to include Prevalon boots. R3's documented services from September 1 through September 28, 2021, indicated R3 received daily range of motion stretches. R3's record lacked orders for Prevalon boots including the frequency to be worn and an order for range of motion stretches/exercises. R3's prescriber orders dated March 23, 2021, included an order for Osmolite 1.4, 90 milliliters/hr for twelve hours overnight. On September 28, 2021, at approximately 8:35 a.m., unlicensed personnel (ULP)-F was observed to provide personal hygiene cares to R3, including adjusting his Prevalon boots. R3's record lacked a written statement of of the treatments services R3 received. In addition, R3's record lacked an individualized treatment and therapy plan to include: -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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.	01940		

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01940	Continued From page 117 On September 29, 2021, at 12:45 p.m., RN-B acknowledged R3's record lacked a treatment plan. The licensee's Development and Revision of the Service Plan policy dated November 23, 2020, indicated the service plan is consistent with accepted standards of practice for professional nursing, therapy or other relevant professional standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	01950		

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01950	Continued From page 118 (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 specific written instructions for each resident were documented in one of one resident's record (R1) who received blood glucose monitoring. 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: R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received blood glucose (sugar) checks twice a day as ordered by the prescriber. R1's prescriber orders dated September 22, 2021, included an order for blood glucose checks two (2) times a day twice weekly.	01950		

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01950	Continued From page 119 R1's documented services from August 1, 2021, through September 28, 2021, directed for blood glucose checks to be completed two times a day twice a week (on Tuesdays and Thursdays). R1's record indicated blood glucose checks had been completed five (5) times with results ranging from 97 to 128 milligrams (mg)/deciliter (dL). R1's record lacked specific written instructions to include parameters for monitoring the blood glucose results. On September 29, 2021, at approximately 12:25 p.m. registered nurse (RN)-B confirmed R1's record did not have specific instructions for blood glucose parameters and instructions of when the ULP would notify the RN. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated November 23, 2021, indicated all treatment and therapy orders must contain information needed to administer the treatment or therapy and any parameter or instructions to hold or modify the therapy as applicable. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated November 23, 2020, noted treatment or therapy tasks may be delegated to ULP. When a treatment or therapy task is delegated to a ULP the RN must develop written specific instructions for each resident and document those instructions in the resident's record; and communicate with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01950		

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01950	Continued From page 120 days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for two of two residents (R1 and R3) reviewed who received 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: R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases	01960		

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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
01960	Continued From page 121 (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked a service plan; however, R1's "care plan" last revised February 2, 2019, indicated the resident received blood glucose (sugar) checks twice a day as ordered by the prescriber. R1's prescriber orders dated September 22, 2021, included an order for blood glucose checks two (2) times a day twice weekly. R1's documented services from August 1, 2021, through September 28, 2021, included blood glucose checks two times a day twice a week (on Tuesdays and Thursdays); however, it lacked documentation R1 received blood glucose checks on 23 of the 29 opportunities. On September 29, 2021, at approximately 12:22 p.m., registered nurse (RN)-B confirmed R1's record lacked documentation of her blood glucose checks as ordered above. R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked an order for range of motion stretches/exercises. On September 28, 2021, at approximately 8:35 a.m., unlicensed personnel (ULP)-F was observed to provide personal hygiene cares to R3, including adjusting Prevalon boots.	01960		

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	30361	A. BUILDING: _____ B. WING _____	09/30/2021

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01960	Continued From page 122 R3's documented services from September 1 through 28, 2021, included scheduled daily stretches; however, it lacked documentation R3 received the services on 21 of 28 opportunities. On September 29, 2021, at approximately 12:45 p.m., licensed assisted living director (LALD)-A and RN-B confirmed R3's record lacked documentation of the daily stretches. The licensee's Content of Client Records policy revised November 23, 2020, indicated the resident record would include documentation of services provided as identified as part of the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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 observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were	01970		

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01970	Continued From page 123 maintained for one of three residents (R3) 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: During the entrance conference on September 27, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment ant therapy services to residents. R3's record did not include a prescriber's order for Prevalon boots (pressure relieving boots) and range of motion stretches/exercises. R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration, feeding tube management, range of motion exercises/stretches, catheter management, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. The "care plan" did not include a written statement of the treatment services the resident received to include Prevalon boots. R3's documented services from September 1 through 28, 2021, included daily stretches and repositioning every two hours to prevent skin	01970		

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01970	Continued From page 124 breakdown. R3's record lacked orders for Prevalon boots including frequency to be worn, and lacked an order for range of motion stretches/exercises. On September 28, 2021, at approximately 8:35 a.m., unlicensed personnel (ULP)-F was observed to provide personal hygiene cares to R3, including adjusting the Prevalon boots. On September 29, 2021, at 12:45 p.m., RN-B acknowledged R3's record lacked prescriber's orders for the above treatments. The licensee's Requesting and Receiving Medication Prescriptions, Refills, and Treatment Orders dated November 23, 2020, indicated the RN was responsible for assuring that current, authorized prescriber orders were kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=E	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 125 Based on observation, interview and record review, the facility failed to provide a hazard vulnerability or safety risk assessment for the facility. This had the potential to affect all dementia care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: On September 28, 2021, at approximately 3:05 p.m., licensed assisted living director (LALD)-A provided records for review. The facility failed to provide a hazard vulnerability or safety risk assessment. On September 28, 2021, between 11:30 a.m. and 3:00 p.m., survey staff toured the facility with LALD-A and maintenance-L. The following observations were made and verified with maintenance-L: - fence gates were not locked in resident outdoor recreation area used by dementia care residents; - gas fireplace in the Oaks building did not have prevention measures in place to protect residents from contacting hot surfaces when fireplace used. LALD-A stated the gas fireplace was used; - gate style doors separating the kitchen from resident dining area in the Oaks building were not secure. At approximately 2:55 p.m., the doors were noted as open and kitchen was unstaffed;	02040		

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02040	Continued From page 126 - the style of the kitchen gate doors when closed would not prevent a resident from entering the kitchen when staff are not present. LALD-A stated the cooking range was not disconnected during times when kitchen is not staffed in the Oaks building; and - laundry room door was open in the Oaks building and not staffed during facility tour. On September 28, 2021, at 3:05 p.m., LALD-A confirmed the facility failed to provide a hazard vulnerability or safety risk assessment for the facility. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event	02110		

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02110	Continued From page 127 a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. 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:	02110		

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02110	Continued From page 128 The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. The licensee's policies were reviewed on September 29, 2021, and the following required policies and procedures were not developed/implemented: -Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -Staff training specific to dementia care; -Description of life enrichment programs and how activities are implemented; -Description of family support programs and efforts to keep the family engaged; -Limiting the use of public address and intercom systems for emergencies and evacuation drills only; -Transportation coordination and assistance to and from outside medical appointments; and -Safekeeping of residents' possessions. On September 29, 2021, at approximately 12:30 p.m. licensed assisted living director (LALD)-A confirmed the licensee had not developed the above required policies and procedures. The licensee's Dementia Program Disclosure	02110		

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02110	Continued From page 129 Requirements (for agencies that are part of a specialized memory care) policy revised November 23, 2020, indicated a written statement called the "Dementia Program Disclosure" would be offered to residents and resident family or representatives; however, the policy lacked development of the above required policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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	02140		

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02140	Continued From page 130 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 27, 2021, at approximately 10:30 a.m., registered nurse (RN)-B stated she was hired to provide direct resident cares and supervision of unlicensed staff, including training. RN-B was hired August 1, 2021. RN-B's background prior to assisted living was working as a RN for inpatient psychiatric care. On September 29, 2021, at 1:35 p.m., licensed assisted living director (LALD)-A stated RN-B and licensed practical nurse (LPN)-C were responsible for training of new employees; however, neither were considered the designated dementia trainer. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	02140		
02170 SS=F	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:	02170		

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02170	Continued From page 131 (1) past and current interests; (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 have an evaluation for an activity plan for four of four residents (R1, R2, R3 and R4) who received services under an assisted living with dementia care license.	02170		

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02170	Continued From page 132 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: R1, R2, R3 and R4's records lacked an activity plan to include all required content. R1 R1's diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), pressure ulcer of left heel, atrial fibrillation (an irregular often fast heart rate), and chronic kidney disease. R1's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included, but were not limited to,	02170		

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02170	Continued From page 133 anxiety, hypertension (high blood pressure), atrial fibrillation, depression, and chronic pain. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. R3 R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R3's record lacked the development	02170		

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02170	Continued From page 134 of an individualized activity plan. R4 R4's diagnoses included, but were not limited to, anxiety, depression, schizoaffective disorder (mental disorder of combination of symptoms of schizophrenia and mood disorder) and Parkinson's disease. R4's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R4's record lacked the development of an individualized activity plan. On September 29, 2021, at approximately 1:00 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not completed an activity evaluation, or developed a plan for any of the current residents. The licensee did not have policy related to activity evaluation and plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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02240	Continued From page 135	02240		
02240 SS=F	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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	30361	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

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02240	Continued From page 136 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 observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for four of four residents (R1, R2, R3 and R4) 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 had a current assisted living with dementia care license. R1 On September 28, 2021, at approximately 6:45 a.m., unlicensed personnel (ULP)-H was observed to administer R1 her scheduled morning medication. R1's Resident Acknowledgement Form dated	02240		

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02240	Continued From page 137 April 1, 2016, indicated R1 had received a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers. R2 On September 28, 2021, at approximately 7:45 a.m., ULP-H was observed to administer R2's morning medications. At approximately 8:10 a.m., ULP-I was observed to assist R2 with dressing, grooming and toileting. R2's Record of Acknowledgement dated July 16, 2021, indicated R2 had received a copy of the Minnesota Home care Bill of Rights. R3 On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3. R3's Record of Acknowledgement Form dated June 27, 2019, indicated R3 had received a copy of the Minnesota Home Care Bill of Rights. R4 On September 28, 2021, at approximately 6:50 a.m., ULP-E was observed to provide medication administration to R4. R4's Record of Acknowledgement Form dated June 30, 2020, indicated R4 had received a copy of the Minnesota Home Care Bill of Rights. On September 29, 2021, at approximately 12:15 p.m., licensed assisted living director (LALD)-A verified R1, R2, R3, R4, and all other residents at the facility, had not received the current Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021.	02240		

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02240	Continued From page 138 The licensee's Home Care Bill of Rights policy dated November 23, 2020, noted the licensee would ensure that each resident received a copy of the Home Care Bill of Rights that was current and applicable to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02270 SS=F	144G.90 Subd. 4 Notice of available assistance A facility shall provide each resident with identifying and contact information about the persons who can assist with health care or supportive services being provided. A facility shall keep each resident informed of changes in the personnel referenced in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post daily staffing information to keep each resident informed about persons who can assist with health care or supportive services being provided. 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).	02270		

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02270	Continued From page 139 The findings include: Upon arrival to the facility on September 27, 2021, at approximately 10:30 a.m., no information of daily staffing was observed to be posted for resident review. During the entrance conference on September 27, 2021, at approximately 10:45 a.m., licensed assisted living director (LALD)-A stated staffing was based on the case mix of residents, with a typical ratio of one caregiver to 10 residents. LALD-A stated she was unaware of the requirement of posting daily staffing information. The licensee did not have a policy or procedure related to posting of daily staffing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02270		
02310 SS=D	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 observation, interview and record review, the licensee failed to provide care and services according the acceptable health care medical or nursing standards of one of one resident (R2) with bedrails and for medication set	02310		

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02310	Continued From page 140 up by unlicesensed personnel for two of two residents (R3, R15) reviewed. In addition, the licensee failed to ensure safe storage of oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: BED RAIL R2 R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation (irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, toileting. On September 28, 2021, at approximately 8:10 a.m., unlicensed personnel (ULP)-I entered R2's room to provide morning cares. R2's bed was noted to have a stationary upper bedrail in the upright position on the right side of the resident's bed. ULP-I had R2 grab the bed rail and while R2 placed pressure on the bed rail ULP-I assisted R2 upright to a seated position on the side of the bed. The bed rail appeared to be secure when the resident placed pressure on the bed rail to position herself. R2's record lacked evidence a bed rail assessment had been completed and an explanation of the risks and benefits of the use of	02310		

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02310	Continued From page 141	02310		

the bed rail had been provided to the resident or the resident's representative.
On September 28, 2021, at approximately 11:55 a.m., licensed practical nurse (LPN)-C confirmed R2 used the bed rail to assist with positioning and mobility. LPN-C measured R2's bed rail and verified the opening of zone 1 (see zone guidance below) measured 18 inches vertically and 12 inches horizontally.
On September 29, 2021, at approximately 12:45 p.m., registered nurse (RN)-B verified R2's bed rail had not been assessed for safety and that the licensee did not provide education to the resident or the resident's representative regarding the risks and benefits of having a bed rail.
The licensee's Assessing the Safety of Side Rails policy dated November 23, 2020, indicated the RN would evaluate whether the side rail appeared to be safe for the resident. The RN would educate the resident, the resident's representative and/or family members about the risks related to side rails. The RN would document recommended options and response from the resident, resident's family and resident's representative.
The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.
The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep

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02310	Continued From page 142 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". MEDICATION SETUP BY ULP R3 ULP-F completed medication setup for later administration for R3. R3's diagnoses included, but were not limited to, quadriplegia, alcohol abuse, orthostatic hypotension (positional blood pressure decrease) and nicotine dependence. R3's record lacked a service plan; however, R3's "care plan" last revised June 3, 2021, indicated the resident received services which included medication administration. R3's record lacked prescriber orders. On September 28, 2021, at approximately 8:35 a.m., ULP-F was observed to provide personal hygiene cares to R3 and to prepare R3's medications for administration via feeding tube. R3's medications were set up in a medication planner. ULP-F stated herself and/or one of the nurses set up R3's medication planner, as R3 wanted his medications available in his apartment. On September 28, 2021, at 1:15 p.m., ULP-F was observed to setup R3's weekly medication planner. ULP-F stated she frequently set up resident's medications using the Medication Administration Record (MAR) as a guide to help the nurses. In addition, ULP-F stated she did not document the setup in the resident record. On September 29, 2021, at 12:45 p.m., RN-B stated medication setup was to be completed by herself or the licensed practical nurse (LPN); however, ULP-F had assisted with medication setup because she was a trained medication aide (TMA).	02310		

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02310	Continued From page 143 R15 ULP-G completed medication setup for later administration for R15. R15's diagnoses included, but were not limited to quadriplegia, chronic pain and anxiety. R15 lacked a service plan; however, R15's "care plan" last revised June 3, 2021, indicated the resident received medication management services. R15's prescriber orders dated June 11, 2021, included an order for vitamin D3 2000 units daily, sertraline 50 mg (antidepressant) daily, and vitamin C 1000 mg daily; and prescriber orders dated August 27, 2021, included but were not limited to, senna-docusate sodium 8.6-50 milligrams (mg) (laxative) to administered two tabs in the morning and one tab at night, and oxybutynin 5 mg (bladder relaxant) daily. On September 28, 2021, at approximately 9:15 a.m. ULP-H was observed to go to the locked medication cupboard and remove a preset medication cup containing pills. ULP-H confirmed the medications were for R15. ULP-H stated ULP-G had set the medications up for her because she was busy getting R15 ready for his appointment this morning. ULP-H proceeded to take the medication cup of pills to R15 who was seated in a wheelchair at a dining room table, and administered the medications to R15 with sips of water. ULP-G confirmed she had preset the following medications up around 9:00 a.m. for R15: senna-docusate sodium 8.6-50 mg, vitamin D3, vitamin C 1000 mg, oxybutynin 5 mg, and sertraline 50 mg for ULP-H to administer. On September 29, 2021, at approximately 1:20 p.m. RN-B confirmed it was not an acceptable practice for a ULP to setup medications for later administration, or to have a ULP setup medications for another ULP to administer. According to the American Nurses Association	02310		

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02310	Continued From page 144 (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. OXYGEN STORAGE On September 28, 2021, at approximately 3:00 p.m. a storage closet in the Birch unit was observed with maintenance-L, who confirmed the storage of the following: - six small oxygen tanks secured in a oxygen caddy; and - three large oxygen tanks, unsecured. On September 29, 2021, at approximately 1:35 p.m., licensed assisted living director (LALD)-A and RN-B confirmed they were unaware of the unsecured oxygen tanks. The licensee's Safe Oxygen Use and Storage policy dated November 23, 2020, indicated oxygen containers must be stored in a well-ventilated area and should not be kept under a bed, in a small area such as a closet or cabinet or covered by linens or clothing. In addition, the policy indicated oxygen containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report	03000		

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03000	Continued From page 145 (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 determine that the reported error was not neglect according to the criteria under section 626.5572,	03000		

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03000	Continued From page 146 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 observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of one resident (R2) 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: On September 27, 2021, at approximately 10:50 a.m. a request was made to licensed assisted living director (LALD)-A and registered nurse (RN)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2021. R2 The licensee failed to immediately report to	03000		

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03000	Continued From page 147 MAARC R2's unaccounted for narcotic loss and/or spillage. R2's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), atrial fibrillation (irregular often fast heart rate), depression, and chronic pain. R2's record lacked a service plan; however, R2's "care plan" last revised July 15, 2021, indicated the resident received medication management services. R2's prescriber orders dated August 17, 2021, included an order for morphine (a moderate to severe controlled substance pain reliever) 4 milligrams (mg) to be administered buccally (in the cheek area of the mouth) every four hours scheduled for pain and 2 mg buccally every one hour as needed for pain/dyspnea (shortness of breath). On September 28, 2021, at approximately 7:45 a.m., unlicensed personnel (ULP)-H was observed to administer R2's scheduled morning medications which included two prefilled syringes of morphine 0.1 milliliters (ml) [equivalent to 4 mg of morphine]. ULP-H stated the nurse setup R2's prefilled morphine syringes. On September 28, 2021, at approximately 10:55 a.m., licensed practical nurse (LPN)-C confirmed herself and RN-B filled and setup the morphine syringes for R2. LPN-C stated the bottle of morphine was stored in the medication refrigerator in the nursing office, and not in the medication refrigerator on the unit. On September 28, 2021, at approximately 11:05 a.m. the locked medication refrigerator in the	03000		

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03000	Continued From page 148	03000		

nursing office was reviewed with RN-B and LPN-C. RN-B verified there currently was 18 ml of morphine concentrate (20 mg/1 ml) in the bottle of morphine. The two (2) narcotic log forms for R2's morphine were reviewed and verified with RN-B with findings listed below:

First narcotic log form
- Entry dated September 8, 2021, noted there was 23 ml (equivalent to 460 mg) of morphine in the bottle;
- Entry dated September 13, 2021, (no time) signed by RN-B (no dual/witnessed signature) read "found bottle had spilt in bag? 16 ml currently in bottle". (This resulted in 7 ml [equivalent to 140 mg] of morphine which was documented, but not witnessed, as being spilled.)
- A second entry dated September 13, 2021, at 2:30 p.m. by RN-B indicated 5 ml of morphine had been drawn up into syringes, leaving an amount of 8 ml in the bottle (according to the narcotic log, there should be 11 ml left in the bottle after the morphine was drawn up into the syringes - not the 8 ml as indicated on the narcotic log form). This was the last entry on the narcotic log form, leaving 11 ml of morphine unaccounted for (equivalent 220 mg).

Second narcotic log form
The second narcotic log form for R2's morphine had entries dated September 19, 2021, thru September 28, 2021.
- Entry dated September 19, 2021, noted a new bottle of 30 ml of morphine was on hand and 4 ml were drawn up into syringes, leaving a new amount of 26 ml of morphine;
- Entry dated September 24, 2021, noted 4 ml of morphine was drawn up into syringes, leaving a new amount of 22 ml;
- Entry dated September 28, 2021, noted 4 ml of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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
03000	Continued From page 149	03000		

morphine 4 ml was drawn up into syringes, leaving a remaining amount of 18 ml (which was the current amount in the bottle).

On September 28, 2021, at approximately 11:10 a.m., RN-B stated the licensee's policy was for two staff members to count the narcotics at the end of each shift. RN-B confirmed R2's morphine was not being counted by two staff members at the end of each shift. RN-B verified the loss and/or spillage of R2's morphine as noted above had not been investigated.

On September 29, 2021, at approximately 1:10 a.m., RN-B and LALD-A confirmed a report had not been submitted to MAARC regarding R2's loss and spillage of R2's morphine, and LALD-A further verified a MAARC report should have been completed and submitted.

The licensee's Vulnerable Adult Reporting and Investigation Policy dated November 23, 2020, noted in accordance with state and federal vulnerable adult laws our licensee's employees would report any suspected maltreatment (abuse, neglect or financial exploitation) of residents. As soon as the resident's immediate safety has been addressed, either the staff witnessing the maltreatment or the RN in charge would notify the Common Entry Point (CEP). If neither the RN nor home care director is available to report the incident within 24 hours, the staff witness would call the CEP directly.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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
03090	Continued From page 150	03090		
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 post a sign related to electronic monitoring at facility entrances. This had the potential to affect all residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On September 27, 2021, at approximately 10:35 a.m., surveyors entered the facility. There was no signage posted at the facility entrance accessible to visitors regarding electronic monitoring devices. On September 27, 2021, at approximately 11:45 a.m. during the tour of the facility with licensed	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30361	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PARK LIVING CENTER LLC	2921 6TH AVENUE NORTH MOORHEAD, MN 56560

(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
03090	Continued From page 151 assisted living director (LALD)-A, cameras were observed mounted on the walls towards the ceiling in the common living room and dining room areas. LALD-A confirmed the facility had working cameras in the common areas and some hallways of the three units. LALD-A confirmed the licensee did not have signage posted at the facility entrance regarding electronic monitoring. On September 29, 2021, at approximately 9:00 a.m., registered nurse (RN)-B provided the licensee's policy book. The licensee lacked a policy regarding electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *09/27/21*
Time: 11:00:15
Report: 1008211026

Food and Beverage Establishment Inspection Report

Location:
Arbor Park Assisted Living
2941 6th Ave N
Moorhead, MN56560
Clay County, 14

Establishment Info:
ID #: N000456
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

Person in charge shall maintain a sick employee log. During the inspection when asked if they had a sick employee log the employees were unaware of a sick employee log.

Comply By: 09/27/21

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Maintain at least the minimum concentration of quaternary ammonium sanitizer within the sani buckets. First tested was 0 ppm. Employee changed out the solution and second test was 400 ppm.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide test strips for all sanitizing solutions. Currently kitchen uses Quaternary Ammonia in sanitizer buckets and currently have test strips for this sanitizer. However the dishwasher uses chlorine and there was no chlorine test strips.

Comply By: 10/01/21

4-500 Equipment Maintenance and Operation

4-501.112A ** Priority 2 **

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

The two salitate kitchens have a residential Amana dishwasher. These units will only reach a maximum hot water sanitizing rise temperate of 155 degrees F, which does not meet the minimum requirement of 165 degrees F. Continued in General Comments.

Comply By: 10/11/21

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

There is no designated hand washing sink in either of the two service kitchens (building 1 or building 2). These kitchens have a domestic 2 well kitchen sink and an undercounter dish machine. Continued in general comments.

Comply By: 09/29/21

2-100 Supervision

2-102.12AMN

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

There is no current certified food protection manager (CFPM). Ensure there is at least one employee that has a current CFPM.

Comply By: 10/27/21

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

The two service kitchens within buildings 1 & 2 have domestic equipment and cabinetry and therefor shall discontinue serving TCS foods that are held for more than same-day service.

Comply By: 09/28/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

Place an internal thermometer in all coolers.

Comply By: 09/30/21

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 hand washing sign at all hand washing sinks. One hand washing sign was handed out during the inspection.

Comply By: 09/29/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0 at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: Yes

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: Dishwasher main kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Eggs 3 door work top Turbo Air
Violation Issued: No

Process/Item: Prep Cooler - Bottom
Temperature: 40 Degrees Fahrenheit - Location: Cheese Turbo Air
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: Ground Beef
Violation Issued: No

Process/Item: Upright Cooler - Single Do
Temperature: 37 Degrees Fahrenheit - Location: Butter - Building 2
Violation Issued: No

Process/Item: Upright Cooler - Single Do
Temperature: 33 Degrees Fahrenheit - Location: Egg - Building 2 Pantry
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler - Single Do
Temperature: 40 Degrees Fahrenheit - Location: Egg - Building 1
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	3	4

4-501.112A: The Amana under counter Dishwasher owners manual states: Sani Rinse water temperature in the final rinse is approximately 155°F (68°C) and that this is a certified residential dishwashers and that certified residential dishwashers are not intended for licensed food establishments.
These two dishwasher will need to be replaced with a dishwasher that meets the minimum hot water sanitizing rise temperature of 165 degrees F.

5-203.11A: It was suggested to designate the left well of the two compartment sink as the designated hand sink and have a hand washing sign (hand washing sign was handed out) and designate the right sink as the scrape/flush sink for the dish machine.

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1008211026 of 09/27/21.

Certified Food Protection Manager: Expired

Certification Number: _____ Expires: / /

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008211026

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	4	**Date**	09/27/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:15
Legal Authority MN Rules Chapter 4626		**Time Out**	

Arbor Park Assisted Living	**Address** 2941 6th Ave N	**City/State** Moorhead, MN	**Zip Code** 56560	**Telephone**
License/Permit # N000456	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status	COS	R
	Supervision		
1	(IN) OUT		
	PIC knowledgeable; duties & oversight		
2	IN (OUT) N/A		
	Certified food protection manager, duties		
	Employee Health		
3	IN (OUT)		
	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT		
	Proper use of reporting, restriction & exclusion		
5	(IN) OUT		
	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices		
6	(IN) OUT N/O		
	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O		
	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands		
8	(IN) OUT N/O		
	Hands clean & properly washed		
9	(IN) OUT N/A N/O		
	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN (OUT)		
	Adequate handwashing sinks supplied/accessible		
	Approved Source		
11	(IN) OUT		
	Food obtained from approved source		
12	IN OUT N/A (N/O)		
	Food received at proper temperature		
13	(IN) OUT		
	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O		
	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination		
15	(IN) OUT N/A N/O		
	Food separated and protected		
16	IN (OUT) N/A		
	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT		
	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status	COS	R
	Time/Temperature Control for Safety		
18	IN OUT N/A (N/O)		
	Proper cooking time & temperature		
19	IN OUT N/A (N/O)		
	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)		
	Proper cooling time & temperature		
21	IN OUT N/A (N/O)		
	Proper hot holding temperatures		
22	(IN) OUT N/A		
	Proper cold holding temperatures		
23	(IN) OUT N/A N/O		
	Proper date marking & disposition		
24	IN OUT (N/A) N/O		
	Time as a public health control: procedures & records		
	Consumer Advisory		
25	(IN) OUT N/A		
	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations		
26	(IN) OUT N/A		
	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances		
27	(IN) OUT N/A		
	Food additives: approved & properly used		
28	(IN) OUT		
	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures		
29	IN OUT (N/A)		
	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	(IN) OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) emailed to HRD **Date:** 09/28/21

Inspector (Signature) Inspector ID# 1008