Electronically Delivered

October 13, 2022

Administrator
Heather Haus
223 4th Street Northwest
Blooming Prairie, MN 55917

RE: Project Number(s) SL30673015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

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

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

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: 507-344-2730 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30673	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30673015 On September 12, 2022, through September 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (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 Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of two residents (R2, R3). 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:	0 430		

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0 430	Continued From page 2 R2 and R3's records lacked evidence a copy of the UDALSA was received. R2 R2 started receiving services from the licensee on December 5, 2016, with diagnoses of hypertension (high blood pressure), depression, and chronic pain. On September 12, 2022, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-E administering medication to R2. R2's service plan dated July 5, 2022, included medication management and assistance with activities of daily living (ADL). R3 R3 started receiving services from the licensee on March 9, 2021, with diagnoses of major depressive disorder and kidney disease. On September 12, 2022, at 12:30 p.m. the surveyor observed ULP-D emptying R3's catheter leg bag. R3's service plan dated July 25, 2022, included medication administration, treatment assistance and assistance with activities of daily living. On September 13, 2022, at 11:30 a.m. licensed practical nurse (LPN)-B confirmed R2's file did not contain a copy of the UDALSA. On September 13, 2022, at 1:40 p.m. registered nurse (RN)-B indicated she was unaware that the UDALSA was a requirement to give to resident/families with the new requirements. RN-B confirmed no one has a UDALSA in their file.	0 430		

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0 430	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, chapter 4626. This had the potential to affect all 18 residents residing at the facility. The findings include: This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 4 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 14, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the 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 develop and implement an individual abuse prevention plan (IAPP) that included an individualized review or	0 630		

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0 630	Continued From page 5 assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 and R3's record lacked evidence of an IAPP. R2 R2 started receiving services from the licensee on December 5, 2016, with diagnoses of hypertension (high blood pressure), depression, and chronic pain. On September 12, 2022, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-E administering medication to R2. R2's service plan dated July 5, 2022, included medication management and assistance with activities of daily living (ADL). R3 R3 started receiving services from the licensee on March 9, 2021, with diagnoses of major depressive disorder and kidney disease. On September 12, 2022, at 12:30 p.m. the	0 630		

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0 630	Continued From page 6 surveyor observed ULP-D emptying R3's urine bag. R3's service plan dated July 25, 2022, included medication administration, treatment assistance and assistance with activities of daily living. On September 9, 2022, at 3:09 p.m. registered nurse (RN)-B indicated she became aware that she needed to implement IAPP for all residents, but had not gotten to it yet. The IAPP had not been done on any of the residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety 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 support protection and safety by not	0 640		

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0 640	Continued From page 7 posting information the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 18 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). The findings include: On September 12, 2022, at 10:00 a.m. during the facility tour with registered nurse (RN)-B, the surveyor found no evidence of a 911 emergency number to be posted in common areas and near telephones provided by the assisted living facility. RN-B confirmed the sign was not posted. On September 12, 2022, at 1:30 p.m. RN-B acknowledged they did not have a 911 sign posted and was unaware of the requirement. 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	0 660		

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0 660	Continued From page 8 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 completion of a facility risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 13, 2022, at 10:00 a.m. registered nurse (RN)-B indicated the TB facility screening was not completed, and she was currently working on it. On September 14, 2022, at 10:00 a.m. RN-B	0 660		

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0 660	Continued From page 9 indicated she had completed the TB facility screening and provided a copy. The TB risk assessment was dated as completed on September 13, 2022, and was determined to be a low risk. The licensee's TB Prevention and Control policy dated November 15, 2017, indicated a TB prevention and control program would be established and maintained based on the CDC guidelines and the home care director is responsible. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 10 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to produce confirming documentation that the fire alarm system had been annually tested and was fully operational in accordance to MNSFC provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was	0 780		

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0 780	Continued From page 11 presented that confirmed annual fire alarm system testing had been completed and matched the date observed on the fire alarm annunciator panel of 08/10/2022 (RN)-B verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800		

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0 800	Continued From page 12 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: 1. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that the fire sprinkler riser indicated that the most recent 5 year system inspection was last conducted on 01/09/2014 - no documentation was presented to confirm that a more recent fire sprinkler system inspection had been completed 2. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was presented to confirm that quarterly inspections of the fire sprinkler system are being completed 3. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed in Room E8, a large free-standing oxygen cylinder (believed to be of size M112). The room was unoccupied, unsecured, and not a med-gas storage room. 4. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed in resident rooms E2 and W8 that extension cords were in use 5. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that in resident room W9 that a 2-to-6 multi-tap adapter was plugged into an outlet and that a power-strip was connected to the adapter (RN)-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30673	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

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0 800	Continued From page 13 (21) days	0 800		
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	0 810		

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	30673	A. BUILDING: _____ B. WING _____	09/14/2022

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0 810	Continued From page 14 by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was presented to confirm 3rd shift fire drills are occuring 2. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was presented to show that annual resident training on evacuation procedures and protocols is being completed 3. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was presented to show that evacuation drills are being conducted 4. On 09/12/2022 between 12:00 AM TO 01:30 PM, survey staff observed that no documentation was presented to show that upon hire and twice annually thereafter that staff are receiving training on fire safety and evacuation	0 810		

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0 810	Continued From page 15 (RN)-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 16	01620		

registered nurse (RN) completed a timely comprehensive reassessment for two of two residents (R2, R3).

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:

R2
R2 started receiving services from the licensee on December 5, 2016, with diagnoses of hypertension (high blood pressure), depression, and chronic pain.

R2's service plan dated July 5, 2022, included medication management and assistance with activities of daily living (ADL).

R2's record included a 90-day assessment dated March 14, 2022, and a 90-day assessment dated July 1, 2022, which was 109 days from the previous assessment.

R3
R3 started receiving services from the licensee on March 9, 2021, with diagnoses of major depressive disorder and kidney disease.

R3's service plan dated July 25, 2022, included medication administration, treatment assistance and assistance with activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30673	A. BUILDING: _____ B. WING _____	09/14/2022

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HEATHER HAUS	223 4TH STREET NW BLOOMING PRAIRIE, MN 55917

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01620	Continued From page 17 R3's record included a 90-day assessment dated March 14, 2022, and a 90-day assessment dated July 1, 2022, which was 109 days from the previous assessment. On September 12, 2022, at 3:09 p.m. RN-B stated she was aware that assessments needed to be completed within 90 days and that not all assessments were completed timely due to short staffing. The licensee's Initial and On-going Nursing Assessment of Clients policy dated January 1, 2015, noted an RN will determine the frequency between assessments not to exceed 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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	01700		

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	30673	A. BUILDING: _____ B. WING _____	09/14/2022

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01700	Continued From page 18	01700		

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 medication management assessments completed by the registered nurse (RN) to determine what medication management services would be provided included all required content for two of two residents (R2, R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

During the entrance conference on September 12, 2022, at approximately 10:00 a.m., RN-B confirmed the licensee provided medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30673	A. BUILDING: _____ B. WING _____	09/14/2022

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01700	Continued From page 19 management services to all 18 residents at the facility. R2 and R3'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' record lacked identification of interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R2 R2 started receiving services from the licensee on December 5, 2016, with diagnoses of hypertension (high blood pressure), depression, and chronic pain. On September 12, 2022, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-E administering medication to R2. R2's service plan dated July 5, 2022, indicated the resident received medication management services including acetaminophen, aspirin, furosemide (a diuretic), lisinopril (used for high blood pressure), and lorazepam (used for anxiety). R3 R3 started receiving services from the licensee on March 9, 2021, with diagnoses of major depressive disorder and kidney disease. R3's service plan dated July 25, 2022, indicated	01700		

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01700	Continued From page 20 the resident received medication management services including acetaminophen, Allegra (for allergies), artificial tears, and buspirone (for major depression). On September 12, 2022, at approximately 3:15 p.m. RN-B indicated she was not aware that a medication assessment was required and it would not be in any of the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/14/22*
Time: 08:35:16
Report: 8044221320

Food and Beverage Establishment Inspection Report

Location:
Heather Haus
223 4th Street Nw
Blooming Prairie, MN55917
Steele County, 74

Establishment Info:
ID #: 0038390
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075837399
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

No thermometer for dishwasher.

Comply By: 09/28/22

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.

No test kit for sanitizer.

Comply By: 09/21/22

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

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

Ecolab chemical dispenser labeled as "water."

Dispenser is missing a label identifying the product as Sink and Surface Sanitizer and Cleaner.

Comply By: 09/14/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

New steam table does not meet ANSI standards.

Comply By: 09/14/23

4-200 Equipment Design and Construction

4-202.15

MN Rule 4626.0535 Remove can openers that have cutting and piercing parts that are not readily removable.

Red-handled can opener blade is not easy to remove.

Comply By: 09/14/22

4-500 Equipment Maintenance and Operation

4-501.11AB

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

Sink and surface sanitizer not dispensing the required concentration of sanitizer.

Comply By: 09/14/22

Surface and Equipment Sanitizers

Lactic Acid: = 452 ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: Yes

Hot Water: = at 174.4 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.1 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

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

Inspection conducted with HRD team lead, Tracey Fearon.

Report reviewed on site with RN Manager, Sue.

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 8044221320 of 09/14/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Inspector signed for Sue

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us