DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 28, 2023

Licensee
Mill City Senior Living
1520 17th Street Northwest
Faribault, MN 55021

RE: Project Number(s) SL34320015

Dear Licensee:

On April 25, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 16, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Electronically Delivered

March 17, 2023

Licensee
Mill City Senior Living
1520 17th Street Northwest
Faribault, MN 55021

RE: Project Number(s) SL34320015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 16, 2023, 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.

LICENSING ORDERS
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, the following fines are assessed pursuant to this evaluation:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after 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 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

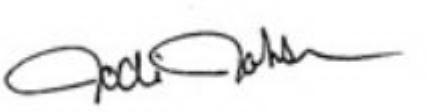
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34320	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CITY SENIOR LIVING	1520 17TH STREET NW FARIBAULT, MN 55021

(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 ******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: SL34320015 On February 13-16, 2023, 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 87 active residents; 58 of whom were receiving services under the Assisted Living/ Dementia Care license. 2310: An immediate correction order was issued on February 14, 2023, at approximately 1:30 p.m. The immediacy was removed; however, non-compliance remains at a level 3, was issued at a and was issued at a pattern scope. 1290: An immediate correction order was issued on February 15, 2023, at approximately at 2:10 p.m. The immediacy was removed; however, non-compliance remains at a level 3, was issued at a widespread scope.	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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0 450	Continued From page 1	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; 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 one of five residents (R4). 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: R4 started receiving services from the licensee on May 1, 2021, to assist with bathing, dressing, behavior observation, medication administration,	0 450		

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0 450	Continued From page 2 and transferring. On February 13, 2023, at 12:30 p.m. the surveyor observed unlicensed personnel (ULP)-D assisting R4 in transferring and toileting. R4's record lacked evidence a copy of the updated Bill of Rights was provided to the resident/representative. On February 16, 2023, at 12:26 p.m. executive director (ED)-A confirmed R4 did not have an updated Bill of Rights. The ED-A stated newer residents had received it, but none of the legacy residents. The licensee's service plan guidelines last revised March 2021, indicated to ensure compliance, any changes to the service plan or agreement must be in writing and must be signed by the client or the client's responsible person and the registered nurse (RN). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
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: (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 3 Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 14, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 4 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 record review, interview, and observation, the licensee failed to conduct evacuation drills for employees at least twice per year per shift, with at least one evacuation drill every other month. These deficient practices had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 5 The findings include: An interview and record review were conducted on February 16, 2023, at approximately 9:30 a.m. with the Regional Environmental Services Lead (RES)-M and Maintenance Director Environment (DM)-N on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. A record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. The provided documentation indicated that the drills were conducted on 2/22/22 (1st shift) and 1/21/22 (3rd shift), with no further drills being documented since December 2021. During the interview, RES-M stated that DM-M was hired a couple of months ago, and RES-M was recently transitioning into the current role, and they were not aware of the requirements. RES-M and DM-M verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be	01290		

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01290	Continued From page 6 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-G). This had the potential to affect all residents currently receiving services. This resulted in an immediate correction order on February 15, 2023, at 2:10 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: ULP-G had a hire date of September 20, 2022. ULP-G's employee record included a Final Registry Results Form dated October 24, 2022, from the Minnesota Department of Human Services (DHS). ULP-G's employee record	01290		

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01290	Continued From page 7 lacked evidence of a background clearance as required. On February 14, 2023, at 8:20 a.m., ULP-G was observed to independently provide transfer, ambulation, dressing, grooming, and catheter cares for R3 in her room. ULP-G stated she was an "on-call" employee, that worked all floors, with all the residents in the facility. On February 15, 2023, at 1:45 p.m., executive director (ED)-A confirmed ULP-G was not listed on their roster and stated the employee must not have completed the fingerprinting process. ED-A indicated there had been a change in management late last fall and background studies were not followed up on. ED-A further stated all new employees are now placed on an outlook calendar for business office manager (BOM)-L to track fingerprinting completion and background study clearance letters. On February 15, 2023, at 2:10 p.m. ED-A verified ULP-G had been working independently with all residents in the facility. The licensee's Workforce Clearance Procedure policy revised January 2017, included the licensee conducted background checks as part of the hiring process. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was removed as confirmed by email correspondence with evaluation supervisor on February 16, 2023; however, noncompliance remains at a scope and severity of I.	01290		

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01290	Continued From page 8 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

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01370	Continued From page 9 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of four unlicensed personnel (ULP-D) to include all required content. 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: ULP-D was hired on February 7, 2022, to provide direct care services to residents at the assisted living facility. On February 14, 2023, approximately 8:00 a.m. the surveyor observed ULP-D administering medication to many residents in the memory care unit. ULP-D's employee record did not include documentation of a competency in appropriate and safe techniques in personal hygiene and grooming. On February 16, 2023, at 8:40 a.m. registered nurse (RN)-B confirmed ULP-D's employee	01370		

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01370	Continued From page 10 record did not contain demonstration and competency for the required training. RN-B explained the form was created to provide signoff for the competency section and was not sure why it was not signed off. The licensee's Nursing Services policy revised March 2021, indicated that proper training and instructions have been provided to verify the ULP is competent, and that documentation is on file indicating the ULP has completed the training and has written proof of the ULP's competency via a written, oral, or practical skills test demonstration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34320	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CITY SENIOR LIVING	1520 17TH STREET NW FARIBAULT, MN 55021

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01380	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of four unlicensed personnel (ULP-D). 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: ULP-D was hired on February 7, 2022, to provide direct care services to residents at the assisted living facility. ULP-D's employee record lacked evidence ULP-D had received the following training and competency: - reading and recording temperature, pulse, and respirations of the resident; and - safe transfer techniques and ambulation. On February 16, 2023, at 8:40 a.m. registered nurse (RN)-B confirmed ULP-D's employee record did not contain demonstration and competency for the required training. RN-B further explained the form was created to provide signoff for the competency section, and was not sure why it was not signed off. The licensee's Nursing Services policy revised March 2021, indicated that proper training and	01380		

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01380	Continued From page 12 instructions have been provided to verify the ULP is competent, and that documentation is on file indicating the ULP has completed the training and has written proof of the ULP's competency via a written, oral, or practical skills test demonstration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an individualized	01610		

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01610	Continued From page 13 assessment for one of five residents (R5) 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). The findings include: R5 was admitted to the facility November 22, 2022, with a diagnosis of dementia, prostate cancer, chronic depression, and back pain. R5's service plan dated November 22, 2022, indicated the resident received assistance with bathing, dressing, toileting, laundry, medication management, and safety checks. On February 15, 2023, at 11:45 p.m. the surveyor observed unlicensed personal (ULP)-K assisting R5 with ambulation, transfer, and feeding cues. R5's record contained a nursing assessment dated December 1, 2022, (nine days after admission). R5's record lacked evidence a comprehensive assessment was completed on or before admission to the facility. On February 16, 2023, 9:00 a.m. RN-B confirmed R5's record lacked evidence of an individualized nursing assessment prior to, or on the date of admission.	01610		

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01610	Continued From page 14 The licensee's Comprehensive Assessment Schedule policy reviewed August 2022, indicated a pre-admission assessment includes a level of care tool, brief interview for mental status (BIMS) tool, and a Medication/treatment management plan tool and at the 14-day assessment an individualized nursing assessment is completed. The policy indicates a temporary plan and agreement is required if an initial individualized assessment is not completed prior to initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=D	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	01620		

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01620	Continued From page 15 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) conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of five residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 admitted to the facility on May 3, 2021, with a diagnosis of unspecified dementia, diabetes, and depression. On February 13, 2023, at 12:30 p.m. the surveyor observed unlicensed personal (ULP)-D assisting R4 in toileting. ULP-D asked for assistance with a two-person transfer. R4's Service Addendum to the Assisted Living Contract (identified as the service plan) signed	01620		

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01620	Continued From page 16 August 25, 2021, indicated R4 received services including medication administration, bathing, dressing, grooming, behavior observation, assistance with transfers, and toileting. R4's record indicated the last two assessments by the registered nurse (RN) were completed as follows: - April 29, 2022, - November 17, 2022, (202 calendar days from the last date of assessment) exceeding the required 90 calendar days. On February 15, 2023, at 10:00 a.m. RN-B confirmed R4's assessments exceeded 90 calendar days, and there were no other assessments between April 2022, and November 2022. R3 R3's Service Addendum to the Assisted Living Contract (identified as the service plan) signed by R3 on September 22, 2021, indicated R3 received services including medication administration, bathing, dressing, grooming, TED (thrombo-embolic deterrent) socks (compression stockings used to prevent blood clots) on in morning off at bedtime, and assistance to empty catheter bag. R3's last two assessments were requested. Assessments dated August 30, 2022, and December 16, 2022, were provided. The December 16, 2022, assessment was 108 days from the date of the previous assessment, exceeding 90 calendar days. On February 14, 2023, at 3:47 p.m. RN-B confirmed R3's last 90-day assessment was late indicating the new nurses didn't understand the assessment scheduling process.	01620		

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01620	Continued From page 17 The licensee's Comprehensive Assessment Schedule policy reviewed August 2022, indicated ongoing client monitoring and reassessment needed to be completed at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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	01730		

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01730	Continued From page 18 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 interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of five residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include. R5 was admitted to the facility November 22, 2022, with a diagnosis of dementia, prostate cancer, chronic depression, and back pain. R5's service plan dated November 22, 2022,	01730		

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01730	Continued From page 19 indicated the resident received assistance with medication management. R5's medication administration record included acetaminophen, donepezil (for dementia), fexopenadine (allergies), gabapentin (nerve pain), melatonin (insomnia), omeprazole (upset stomach), quetiapine (agitation), and Sertraline (depression). R5's file contained a medication and treatment evaluation and management plan dated December 1, 2022 (nine days after admission). On February 16, 2023, at 8:40 a.m. registered nurse (RN)-B confirmed a medication assessment was not completed prior to admission to the facility. RN-B explained he was originally planned to be admitted to the assisted living side with his wife and she was going to administer his medication; however, due to increased care needs R5 was admitted to the memory care unit with medication management by staff. The licensee's Comprehensive Assessment Schedule revised August 2022, indicated the initial medication management assessment will occur prior to providing medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 20 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of seven residents (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 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 was admitted on January 31, 2020, and started receiving assisted living services on August 1, 2021. R3's diagnosis included Parkinson's disease (brain disorder causing unintended or uncontrollable movements), hypertension (high blood pressure), chronic pain syndrome, bilateral cataract (clouded, blurred, or dim vision), presbyopia (loss of your eyes' ability to focus on nearby objects), and insomnia (trouble falling and/or staying asleep). R3's NEW Nursing Assessment, identified as the most recent comprehensive nursing assessment and medication/treatment management plan	01880		

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01880	Continued From page 21 dated December 16, 2022, indicated R3's medications were stored in a locked cabinet within the apartment. The assessment further identified community licensed and unlicensed staff would be responsible for administering medications. R3's Service Addendum to the Assisted Living Contract (identified as the service plan) signed by R3 on September 22, 2021, indicated R3 received services including medication administration. On February 13, 2023, at 2:24 p.m. in R3's room, the surveyor observed a bottle of ibuprofen 200 milligram (mg)tablets in the front basket of R3's walker. R3 stated she had both ibuprofen (for mild to moderate pain) and Benadryl (for allergic reactions, insomnia, and motion sickness) that she took independently indicating the doctor and licensee were aware. On February 15, 2023, at 10:10 a.m. the surveyor was with R3 in her room. The bottle of ibuprofen remained in her front walker basket. R3 stated she took 600-800 mg of ibuprofen and 25 milligrams (mg) of Benadryl at bedtime each night to help her relax. R3 was unable to locate the bottle of Benadryl during the conversation, and it was not observed by the surveyor. A tube of hydrocortisone cream (relieves redness, itching, swelling, or other discomfort caused by skin conditions) 1% and a tube of Cortizone 10 maximum strength (hydrocortisone cream) was laying on her bedside table. In a clear shoe shaped figurine, on a table next to her recliner chair, were two pink oblong pills and one orange oblong pill. R3 stated the pink pills were Benadryl and the orange pill was ibuprofen.	01880		

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01880	Continued From page 22 On February 15, 2023, at approximately 10:10 a.m. unlicensed personnel (ULP)-M stated R3 received all medications from staff and if any medications were found in a room it would need to be reported to a registered nurse (RN). On February 16, 2023, at 10:50 a.m. RN-B stated there was no order for the medications listed above and no assessment for R3 to self-administer. RN-B indicated the medications should not have been unsecured in R3's room. The licensee's Medication & Treatments Guideline revised March 2021, indicated licensee would store medications consistent with each resident's medication plan and service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01940		

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01940	Continued From page 23 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R4) who had treatments 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 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 February 13, 2023, at 10:15 a.m., registered nurse (RN)-B	01940		

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01940	Continued From page 24 stated the licensee provided treatment and therapy services to residents. R4's diagnoses included unspecified dementia, diabetes, and depression. R4's 90-day nursing assessment dated November 17, 2022, indicated R4 required assistance with blood glucose monitoring. R4's February 1, 2023, through February 15, 2023, medication administration record (MAR) indicated R4 received blood glucose monitoring two times daily. R4's service plan dated August 25, 2021, lacked a written statement of the treatment services the resident received to complete blood sugar checks. R4's record did not include evidence of an individualized treatment or therapy management plan which included the following: - procedures for notifying the RN or appropriate licensed health professional when a problem arises. On February 16, 2023, at 10:30 a.m. RN-B confirmed R4's record lacked a treatment management plan for R4's blood glucose parameters to notify the nurse and stated it was not set up in the electronic record. The licensee's Individual Medication & Treatment Management Plan policy updated August 2021, noted the licensee will develop and maintain a current individualized medication and treatment management plan based on the tenant's assessment. The plan with identify tenant specific instructions for documenting medication or treatment administration verification.	01940		

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	34320	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CITY SENIOR LIVING	1520 17TH STREET NW FARIBAULT, MN 55021

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01940	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 up-to-date written or electronically recorded orders were maintained for one of three residents (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 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 February 13, 2023, at 10:15 a.m. registered nurse (RN)-B, RN-C, and executive director (ED)-A confirmed	01970		

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01970	Continued From page 26 the licensee provided treatment and therapy services to the licensee's residents. R3's diagnosis included Parkinson's disease (brain disorder causing unintended or uncontrollable movements) and hypertension (high blood pressure). On February 13, 2023, at 2:24 p.m. R3 was observed wearing TED (thrombo-embolic deterrent) hose (compression socks used to increase circulation and reduce swelling in the legs) to bilateral lower legs. R3 stated staff put the TED socks on every day and remove at night. R3's NEW Nursing Assessment, identified as the most recent comprehensive nursing assessment and medication/treatment management plan dated December 16, 2022, indicated staff assisted R3 with an exercise program. The assessment did not identify R3 required TED socks. R3's Service Addendum to the Assisted Living Contract (identified as the service plan) signed by R3 on September 22, 2021, indicated R3 received services including TED socks, on in morning, off at bedtime. R3's Service Checkoff List dated February 2023, included a task with staff signatures to apply TED socks to both legs in morning and remove in the evening. R3's record lacked prescriber orders for TED socks. On February 15, 2023, at 2:07 p.m. registered nurse (RN)-B stated R3 wore TED socks applied and removed by staff each day, and verified R3's	01970		

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01970	Continued From page 27 record lacked an order for the treatment. RN-B further stated there should be prescriber orders for treatments. The licensee's Medication & Treatments Guideline revised March 2021, noted the RN was responsible to assure a current authorized prescriber orders for treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the	02040		

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02040	Continued From page 28 ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and interview was conducted on February 16, 2023, at approximately 9:30 a.m. with the Regional Environmental Services Lead (RES)-M and Maintenance Director Environment (DM)-N on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, RES-M and DM-N stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
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	02140		

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02140	Continued From page 29 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 ensure the designated person overseeing staff training in the care of individuals with dementia, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. On February 16, 2023, at 10:00 a.m. registered nurse (RN)-B stated RN-C oversaw the dementia care training for staff. RN-C's employee record indicated she had completed CARES Certification through Healthcare Interactive's (on-line training curriculum) for Dementia Basics and Dementia	02140		

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02140	Continued From page 30 Advanced Care. RN-C's employee record lacked evidence of successful completion of passing a skills competency or knowledge test to be the person in charge of overseeing staff training for dementia care, approved by the Minnesota Department of Health (MDH) commissioner. On February 16, 2023, at 11:23 a.m. RN-B stated the only dementia certification RN-C had completed was from Healthcare Interactive. Though Healthcare Interactive was listed as an approved Alzheimer's Association training program, RN-B was not aware it was not approved by MDH commissioner. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
02170 SS=E	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.	02170		

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02170	Continued From page 31 (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 observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for one of four residents (R2). 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).	02170		

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02170	Continued From page 32 The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. R2 was admitted and started receiving assisted living services on December 12, 2022. R2's diagnoses included chronic obstructive pulmonary disease (lung disease that causes obstructed airflow from the lungs), dysphagia (difficulty in swallowing food or liquid), congestive heart failure (heart doesn't pump blood as well as it should), depression, and history of falling. R2's Service Addendum to the Assisted Living Contract (identified as the service plan) effective January 24, 2023, indicated R2 received services including medication administration, transfer, bathing, dressing, toileting, and ostomy care R2's records lacked an individualized written activity evaluation that addressed: -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 based on the activity evaluation. On February 14, 2023, at 3:24 p.m. activity director (AD)-J stated she had started this position last month and had not been trained on completing the assessments yet. AD-J indicated	02170		

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02170	Continued From page 33 new residents admitted within the last couple of months would be lacking this assessment. On February 15, 2023, at 10:50 a.m. registered nurse (RN)-B verified R2's record lacked a comprehensive activity evaluation and an activity plan that addressed all the required content noted above. The licensee's Social History & Life Pattern Questionnaire Guideline revised July 2021, indicated all residents would have an accurate and current assessment of her/his individual leisure preferences within five days from admission date, annually, and with any change in residency. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for three of thirteen residents (R3, R7, R8) with siderails. This resulted in an immediate correction	02310		

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02310	Continued From page 34 order on February 14, 2023, at approximately 1:30 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 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: R3 On February 13, 2023, at 2:24 p.m., R3's bed was observed to be a hospital style bed with bilateral upright quarter siderails. R3 stated she slept in the bed at night and the siderails "make me feel safer." R3 was admitted on January 31, 2020, and started receiving assisted living services on August 1, 2021. R3's diagnosis included Parkinson's disease (brain disorder causing unintended or uncontrollable movements). R3's Service Addendum to the Assisted Living Contract (identified as the service plan) signed by R3 on September 22, 2021, indicated R3 received services including medication administration, bathing, dressing, grooming, and assistance to empty catheter bag. R3's NEW Nursing Assessment, identified as the most recent comprehensive nursing assessment,	02310		

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02310	Continued From page 35 dated December 16, 2022, identified R3 was alert and orientated, had a history of falls, balance problems while standing or walking, and required use of assistive device for mobility. The assessment indicated a "U" type grab bar/siderail was slid under the mattress and in place bilaterally to R3's bed. The assessment indicated risk and benefits of siderails were reviewed with resident. R3's medical record did not include evidence of a hospital bed siderail assessment or measurements. On February 14, 2023, at 12:43 p.m., registered nurse (RN)-C accompanied surveyor to R3's room and confirmed R3 had a hospital bed with bilateral upright quarter siderails on upper quadrant. RN-C further confirmed R3's assessment did not identify or include measurements for hospital bed siderails. On February 14, 2023, at 1:23 p.m., RN-B verified R3's medical record lacked a siderail assessment and measurements. R7 On February 14, 2023, at 1:50 p.m., the surveyor along with RN-C, observed bilateral halo siderails near the head of R7's bed. The siderails were attached to the metal bed frame and attached together under the bed. RN-C indicated the siderails were placed by maintenance on February 10, 2023. R7's diagnoses included Type 2 diabetes with unspecified complications, Alzheimer's disease, and peripheral neuropathy. R7's Service Plan dated November 22, 2021,	02310		

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02310	Continued From page 36 indicated services included assistance with bathing, assistance with Ted stockings, laundry, and medication management. R7's siderails were placed on bed following manufacturer's instructions on February 10, 2023. R7's physical device tool assessment was dated February 13, 2023 (after the survey began). The assessment indicated risk versus benefit was reviewed. R8 On February 14, 2023, at 2:00 p.m., the surveyor along with RN-C, observed bilateral halo siderails near the head of R8's bed in the up position. The siderails were attached to the bed frame. R8 stated she used them all the time. R8's diagnoses included Type 2 diabetes with unspecified complications, hemiplegia (one sided weakness), and hypertension (high blood pressure). R8's service plan dated October 29, 2021, included assistance with bathing, dressing, housekeeping, and daily medication administration. R8's new nursing assessment, physical device section, dated February 5, 2023, indicated risk versus benefit was completed but did not contain evidence the manufacturer's recommendations were reviewed, and that the website was reviewed for device recalls. The Food and Drug Administration (FDA) Side Rail Entrapment Zones and Dimensional Recommendations dated March 10, 2006, indicated to reduce the risk of entrapment, zone	02310		

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02310	Continued From page 37 one (space between the rails), should be less than four and three quarters' inches. The FDA's "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." The licensee's Resident Assistive Device policy last revised December 2022, indicated that clinical staff will be responsible for completing the appropriate assessments and reviewing the risk benefits with residents and responsible parties. For non-hospital style beds, the licensee will refer to individual manufacturer's guidelines for proper installation and up to date information related to recall information. For hospital style beds, an assessment will be completed by nursing with measurements and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was removed; however, non-compliance remains at a level 3, and was issued at a pattern scope. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *02/14/23*
Time: 12:46:23
Report: 8074231030

Food and Beverage Establishment Inspection Report

Location:
Mill City Senior Living
1520 17th Street Nw
Faribault, MN55021
Rice County, 66

Establishment Info:
ID #: 0038505
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074972011
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

chicken cooling on counter 117 df in deep plastic container, moved to walk-in cooler in shallow metal pan. soup in walk-in has heavy condensation on lid.

Comply By: 02/14/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

no thermometer or stickers for dish machine

Comply By: 02/14/23

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

utensils stored food contact up, corrected on site.

Comply By: 02/14/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

plumbing under handsink has black from leaking. floor of dry storage has food debris.

Comply By: 02/14/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: dish machine internal
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 117 Degrees Fahrenheit - Location: chicken
Violation Issued: No

Process/Item: Cooling
Temperature: 124 Degrees Fahrenheit - Location: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: tomato soup
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 40 Degrees Fahrenheit - Location: eggs
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: milk
Violation Issued: No

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

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 8074231030 of 02/14/23.

Certified Food Protection Manager: Maria Benzick

Certification Number: FM108498 Expires: 10/21/24

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us