October 30, 2023

Licensee
The Legacy of Delano
1350 St. Peter Avenue East
Delano, MN 55328

RE: Project Number(s) SL29189015

Dear Licensee:

On October 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 2, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 15, 2023

Licensee
The Legacy of Delano
1350 St. Peter Avenue East
Delano, MN 55328

RE: Project Number(s) SL29189015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH 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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

A state correction 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 MDH 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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: SL29189015-0 On July 31, 2023, through August 2, 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 53 active residents; 47 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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: 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 August 1, 2023, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for four of four unlicensed personnel (ULP) (ULP-G, ULP-J, ULP-I, ULP-K) providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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: ULP-G On August 1, 2023, at 7:07 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R1. ULP-G did not complete hand hygiene before or after R1's medications. At 7:13 a.m., ULP-G donned (put on) a pair of gloves and administered R1's eye drops, doffed (removed) gloves, and applied hand sanitizer. At 7:44 a.m., ULP-G entered R13's apartment and completed R13's schedule morning medication administration. ULP-G did	0 510		

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0 510	Continued From page 3 not perform hand hygiene before or after. At 7:46 a.m., ULP-G completed R14's medication administration and did not perform hand hygiene before or after. At 7:49 a.m., ULP-G donned a pair of gloves and administered R14's eye drops, ULP-G doffed gloves, and did not perform hand hygiene. At 8:34 a.m., ULP-G completed medication administration for an unidentified resident. ULP-G did not complete hand hygiene before or after the medication administration. At 8:48 a.m., ULP-G entered R2's apartment and removed a soiled pad off R2's chair with a gloved hand. ULP-G doffed the glove, did not perform hand hygiene, and placed a new pad on R2's chair. ULP-G donned gloves and emptied R2's catheter bag, wiped the bag with an alcohol wipe, discarded the urine in the toilet, doffed gloves, and donned a new pair of gloves without completing hand hygiene. ULP-G proceeded to bring R2's dentures, removed gloves and started the R2's medication administration process without hand hygiene. On August 1, 2023, at 9:15 a.m., ULP-G stated hand hygiene was not done frequently, and hand sanitizer was not available to use in every resident room. ULP-J On August 1, 2023, at 7:20 a.m., the surveyor observed ULP-J walk into R7's room, unlock medication cupboard, set up R7's morning medications, administer medications to R7, and documented the administration of R7's medications on the EMAR (electronic medical record). ULP-J left R7's room and walked into R8's room; without washing hands, ULP-J set up R8's morning oral medications, donned gloves and applied Voltaren gel (arthritic pain relief) onto a paper strip, then with her gloved hand wiped the	0 510		

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0 510	Continued From page 4 Voltaren gel onto a finger on her gloved right hand. ULP-J then applied the Volteran gel to R8's right knee and administered R8's morning oral medications. ULP-J doffed gloves, did not wash hands, and documented the administration of R8's medications on the EMAR. ULP-J did not wash hands before ULP-J entered R10's room at 7:35 a.m. ULP-J donned gloves to both hands, and assisted R10 to put hearing aids in. ULP-J doffed gloves and donned a new pair of gloves and assisted R10 with a putting on her TED stockings (compression stocking), assisted R10 to walk into the bathroom, lower pants, and adult brief. ULP-J doffed gloves, and without completing hand washing, ULP-J unlocked medication cupboard, donned gloves, applied Voltaren gel to a measuring strip, wiped the Voltaren gel onto ULP-J's gloved finger, and applied the Voltaren gel to R10's knees. ULP-J doffed gloves, and without completing hand washing, donned new gloves and applied nystatin powder to abdominal folds. ULP-J doffed gloves, and without completing hand washing, donned new gloves and removed R10's adult brief that was wet and applied a new adult brief. With the same gloved hands, ULP-J assisted R10 to remove top, put bra on and put top back on. ULP-J had R10 stand up, performed peri care, and with the same gloved hands assisted R10 to pull up adult brief and pants. ULP-J then doffed gloves, left room, and did not complete hand washing. On August 1, 2023, at 7:50 a.m., ULP-J stated she did not wash her hands after removing gloves or in between providing residents cares. ULP-J stated after changing gloves three times she would wash her hands. ULP-I	0 510		

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0 510	Continued From page 5 On August 1, 2023, at 8:00 a.m., the surveyor observed ULP-I administer R6's morning medications in the dining room. ULP-I documented R6's medication administration on the EMAR. ULP-I did not wash her hands. ULP-I entered R11's room. ULP-I identified water on the floor in R11's bathroom. ULP-I donned gloves and wiped up the water on R11's bathroom floor. ULP-I doffed gloves, and did not wash hands. ULP-I went on to set up R11's morning medications, administer R11's medications and document the administration of the medications on the EMAR. ULP-I donned gloves to hands and applied Triamcinolone cream to R11's rash on neck. ULP-I doffed gloves, documented on the EMAR, and left room without washing her hands. ULP-I then entered R9's room, donned glovess, assisted R9 to get dressed, walked R9 into the bathroom, assisted to pull down pants, adult brief and assist R9 to sit on the toilet. ULP-I removed wet brief. With same gloved hands, ULP-I wet a washcloth and handed it to R9 to wash her face, combed R9's hair, applied powder to R9's abdominal folds and pulled up R9's pants. ULP-I doffed gloves and washed hands. After administering R9's medications, ULP-I removed the garbage from R9's bathroom, brought it to the soiled utility room and directly went into another resident's room and started to make another resident's bed. No hand washing was observed. On August 1, 2023, at 9:00 a.m., ULP-I stated she did not wash her hands after removal of gloves in both R11 and R9's rooms and did not wash her hands in-between providing cares to the residents. ULP-K On August 1, 2023, at 8:02 a.m., the surveyor observed ULP-K complete scheduled morning	0 510		

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0 510	Continued From page 6 medication administration for R15. ULP-K did not complete hand hygiene before or after R15's medications. Immediately following, ULP-K entered R16's apartment to check on R16's oxygen management and then left apartment. ULP-K did not complete hand hygiene before or after providing services to R16. On August 1, 2023, at 1:40 p.m., ULP-K stated hand hygiene was not completed before or after medication administration or in between residents. ULP-K stated, "I normally have hand sanitizer in my pocket." On August 1, 2023, at 9:30 a.m., regional clinical director (RCD)-B stated staff were trained and should be washing hands before applying gloves and after removing gloves, and in-between providing cares to residents. The licensee's Hand Hygiene policy last revised July 2021, indicated alcohol based hand sanitizer should be used immediately before touching a patient, before moving from a soiled body site to a clean body site on same resident, after touching a resident or the resident's immediate environment, and immediately before putting on gloves and after glove removal. When conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before donning gloves and after removing gloves. The licensee's Medications and Treatments policy dated March 2021, indicated the first step to complete when medication administration was provided was to wash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 7 days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for one of one resident (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's diagnoses included Alzheimer's disease, hypertension, acute kidney disease, and fractured hip. R3's service plan dated June 20, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, oral	0 620		

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0 620	Continued From page 8 care, and toileting. R3's Progress Notes indicated the following: -July 10, 2023, at 4:56 a.m., R3 had an unwitnessed fall. R3 fell on the side of bed. HHA (home health aide) stated that it appears that R3 fell out of bed. R3 was unable to state fall details. HHA found R3 on a safety check. R3 did strike his head. Pupils look unequal. The right pupil looks like a keyhole appearance, which is not his normal appearance per HHA. Right sided head bump. R3 is taking blood thinners. No complaints of pain, R3 is unsteady on feet which is unlike him. R3 has a bump to his head and skin tear to right hand. Blood pressure 195/105, heart rate 126, respirations 24, temperature 96.7, and oxygen saturation 91%. R3 got himself up prior to HHA calling triage. Triage RN (registered nurse) instructed HHA to call EMS (emergency medical service) right way due to abnormal vital signs and abnormal/unequal pupils. EMS and family called. -July 10, 2023, 7:12 a.m., R3 was sent to the hospital -July 10, 2023, 11:21 a.m., nurses noted R3 had a fall in R3's apartment. R3 returned to the community at 11:20 a.m. Nursing noted bruise to the left eye reaching above the eyebrow. Light blue in color. R3 has bruises to both arms, purple in color. No other noted concerns noted. R3 stated he was glad to be back. R3's Emergency Room Encounter, dated July 10, 2023, indicated reason for visit fall. Diagnoses include fall, injury of head, and skin tear of right hand without complication. On August 1, 2023, at 2:49 p.m., the surveyor requested an incident report for the July 10, 2023, fall and inquired if a MAARC report had been filed. At 3:16 p.m., regional clinical director	0 620		

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0 620	Continued From page 9 (RCD)-B stated a MAARC report had not been filed for R3's unwitnessed fall with injury on July 10, 2023. In addition, RCD-B also stated a MAARC report should of been completed. As of August 2, 2023, at 3:00 p.m., the surveyor had not received an incident report for R3's fall on July 10, 2023. The licensee's Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting policy, last revised October 2022, indicated all facility staff shall immediately make a report to MAARC if the reporter has reason to believe that the vulnerable adult has sustained an injury which is not explained. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	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	0 630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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
0 630	Continued From page 10 by: Based on interview and record review, the licensee failed to ensure the resident's individual abuse prevention plan included all areas of vulnerability for one of four 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's diagnoses included Alzheimer's disease, hypertension, acute kidney disease, and fractured hip. R3's Progress Notes indicated the following: -May 19, 2023, at 8:45 a.m., late entry for May 16, 2023, 4:00 p.m., R3 became angry and raised his hand toward HHA (home health aide) when trying to take R3's blood pressure. -May 19, 2023, at 8:49 p.m., late entry for May 16, 2023, 7:45 p.m., went into R3's apartment to assist with getting ready for bed, resident became a bit aggressive to HHA, would come back later. When HHA came back a little later R3 became upset and refused to get ready for bed. HHA left apartment. R3's New Nursing Assessment/Individual Abuse Prevention Plan (IAPP) dated May 24, 2023, indicated R3 had a potential to abuse self and others, however, no abuse to others had been noted to date. R3 was not susceptible to abuse by	0 630		

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0 630	Continued From page 11 others. R3's Progress Notes indicated the following: -June 3, 3023, at 10:57 a.m., staff went to assist R3 to the dining room for breakfast. Staff said to resident "time to go for breakfast" and resident became upset and "oh you want me to go to breakfast" the pushed his walker toward staff and doorway quite aggressively. R3's New Nursing Assessment/IAPP dated June 20, 2023, indicated R3 had a potential to abuse self and others, however, no abuse to others had been noted to date. R3 was not susceptible to abuse by others. R3's IAPP dated June 20, 2023, did not indicate R3 had the potential to be abused by other vulnerable adults. On August 1, 2023, at 2:49 p.m., regional clinical director (RCD)-B stated R3's IAPP should indicate R3 was susceptible for abuse from other vulnerable adults. RCD-B stated she considers all residents in assisted living as susceptible to abuse by other vulnerable adults. The licensee's Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting policy, last revised October 2022, indicated the facility will evaluate the individual's susceptibility of abuse and also evaluate the individual's risk of abusing other vulnerable adults. The plan will also include the measures to be taken to protect that individual from abuse and to minimize the risk of abuse to other vulnerable adults. No further information was provided.	0 630		

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0 630	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the missing persons policy was reviewed quarterly. This had the potential to affect all 53 residents.	0 680		

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0 680	Continued From page 13 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: During the entrance conference on July 31, 2023, at 1:00 p.m., the surveyor requested the licensee's Emergency Preparedness Plan (EPP), which was later provided for the surveyor to review. The licensee's EPP indicated the last review date was December 2022 and was signed by licensed assisted living director (LALD)-A. The Missing Resident Plan contained in the EPP lacked evidence the policy had been reviewed quarterly, as required. On August 2, 2023, at 1:56 p.m., LALD-A stated the last full review of the EPP was December 2022 and had thought the missing resident plan should be reviewed every 6 months. The licensee's Missing Resident Plan dated July 2021, indicated the assisted living director and clinical nurse supervisor will review all resident elopement plans quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	0 940		

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0 940	Continued From page 15 (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2). This had the potential to affect all 53 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's assisted living contract was signed August 9, 2022. R1's service plan, dated June 23, 2023, indicated services included assistance with bathing, dressing, medication administration, oxygen management, and laundry. On August 1, 2023, at 7:07 a.m., the surveyor observed unlicensed personnel (ULP)-G complete scheduled morning medication administration to R1. R2	0 940		

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0 940	Continued From page 16 R2's assisted living contract was signed March 30, 2023. R2's service plan, dated May 5, 2023, indicated services included assistance with bathing, medication administration, oxygen management, and laundry. On August 1, 2023, at 8:55 a.m., the surveyor observed ULP-G complete schedule morning medication administration to R2. R1 and R2's Assisted Living contracts lacked whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. On August 1, 2023, at 4:00 p.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing and the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	01470		

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01470	Continued From page 17 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01470		

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01470	Continued From page 18 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of five employees (triage registered nurse (TRN)-N). 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: TRN-N was hired on August 11, 2020, to provide supervision under the licensee's Assisted Living with Dementia Care license. R3's Progress Notes dated March 2, 2023, at 7:46 p.m., 9:49 p.m., and 10:06 p.m. written by TRN-N indicated the HHA (Home Health Aide) called TRN-N regarding R3's condition. TRN-N's employee record lacked evidence TRN-N had completed the following orientation to assisted living topics:	01470		

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01470	Continued From page 19 -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 2, 2023, at 3:00 p.m., licensed assisted living director (LALD)-A stated TRN-N had not completed the orientation to assisted living training as indicated above. On August 2, 2023, at 3:00 p.m., the surveyors requested the licensee's Orientation to Assisted Living policy along with other policies. On August	01470		

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01470	Continued From page 20 3, 3023, at 12:01 p.m., LALD-A sent an email to the surveyor that included some of the requested policies but did not include the licensee's Orientation to Assisted Living policy. On August 7, 2023, at 7:26 a.m., a surveyor emailed LALD-A requesting the licensee's Orientation to Assisted Living policy. On August 9, 2023, at 9:58 a.m., LALD-A emailed the licensee's undated Orientation Training Requirements indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01540		

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01540	Continued From page 21 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of five employees (triage registered nurse (TRN)-N) received the required amount of dementia care training in the required time frame. 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: TRN-N was hired on August 11, 2020, to provide supervisor under the licensee's Assisted Living with Dementia Care license. R3's Progress Notes dated March 2, 2023, at 7:46 p.m., 9:49 p.m., and 10:06 p.m. written by TRN-N indicated the HHA (Home Health Aide) called TRN-N regarding R3's condition. TRN-N's employee record lacked evidence TRN-N had completed eight (8) hours of dementia training. On August 2, 2023, at 3:00 p.m., licensed assisted living director (LALD)-A stated TRN-N had not completed the eight (8) hours of dementia training.	01540		

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01540	Continued From page 22 On August 2, 2023, at 3:00 p.m., the surveyors requested the licensee's Dementia Training policy along with other policies. On August 3, 3023, at 12:01 p.m., LALD-A sent an email to the surveyor that included some of the requested policies but did not include the licensee's Dementia Training policy. On August 7, 2023, at 7:26 a.m., a surveyor emailed LALD-A requesting the licensee's Dementia Training policy. On August 9, 2023, at 9:58 a.m., LALD-A emailed the licensee's undated Minnesota Assisted Living (144G). Company standards no matter with or without memory care policy. The licensee's Minnesota Assist Living (144G). Company standards no matter with or with out memory care policy RN (registered nurse) would have eight (8) hours of training within 120 work hours after first day of hire. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=I	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	01620		

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01620	Continued From page 23 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reassessed one of one resident (R3) with falls, and one of one resident with change of condition (R3). In addition, the licensee failed to ensure the uniform assessment tool used contained all required components for two of two residents (R1, R2) and all residents requiring assessments. 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: UNWITNESSED FALLS R3 was admitted on June 16, 2020, and transferred to the secured care unit on June 13, 2023.	01620		

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THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

(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
01620	Continued From page 24 R3's diagnoses included Alzheimer's disease, hypertension, acute kidney disease, and fractured hip. R3's service plan dated June 20, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, oral care, toileting 9:00 a.m. and 12:00 p.m., 4:00 p.m. and 7:00 p.m., escort at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 7:00 p.m., and safety checks 2:00 a.m. and 10:00 p.m. The licensee's Resident/Incident report dated February 20, 2023, to July 27, 2023, indicated R3 had seven (7) reported falls, and additional fall noted in R3's progress notes. FALL WITH INJURY Incident report dated March 20, 2023, at 10:00 a.m., indicated, R3 had a witnessed fall. R3 was walking down the hall and R3's leg gave out and he fell. R3 complained of pain left hip area. Staff member helped resident to his feet and placed him in a nearby chair because he was struggling to stand. Emergency service was called and R3 was transferred to the hospital. Family notified. The Incident Investigation portion on the incident report indicated R3 had no previous falls and no reduction plan in place. R3 was sent to hospital for further observation and evaluation. The Resident Follow-up and Prevention portion of the incident report indicated no environmental modifications, no assistive devices added, and no fall reduction interventions implemented. R3's Progress notes indicated the following: -March 20, 2023, 11:46 a.m., R3 had a fall at 10:00 a.m. Resident was walking down the hall	01620		

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01620	Continued From page 25 and fell. When nurse helped resident up he was unable to bare weight. R3 was sent to ED (emergency department) for further evaluation. (written by LPN (licensed practical nurse). -March 20, 2023, 1:33 p.m., R3 has a left hip fracture and will be admitted. (written by LPN) -April 25, 2023, 3:55 p.m., R3 returned to the community today at 10:00 a.m. Nursing assessment completed. R3 has several bruises to both his arms and two (2) areas that nursing removed band aids cleaned areas and reapplied. Left hip incision looks good, few scabs intact to area. Therapy to start on the 27th. R3 has an increase in services due to R3 needing escorts, one (1) assist with ambulation and transfers. (written by RN) FALLS/UNWITNESSED Incident report dated April 30, 2023, at 7:00 p.m., indicated, R3 had an unwitnessed fall in the resident's bedroom. The facility staff called to report R3 slid off bed and landed in a sitting position. R3 denies pain and hitting head or losing consciousness. R3 denies dizziness or nausea. R3's skin is intact. R3's maintains base line range of motion of all four extremities. R3 was assisted back to bed with one person assist. Blood pressure 136/74, heart rate 103, respirations 16, and oxygen saturation 97%. The facility staff advised to increase safety checks per facility protocol and call triage back for any new or worsening symptoms. Family was notified. The Incident Investigation portion of the incident report indicated there was no previous history of this type of incident, and there was no reduction plan in place. Contributing factors include R3 did not call for assistance, no shoes on, and cognitive impairment. Contributing resident factors include gait/balance disorder, impaired safety judgement. R3 did not utilize pendant to call for assist.	01620		

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01620	Continued From page 26 Attempted self-transfer. Resident follow-up and prevention portion on the incident report indicated education on safety, note on walker to use walker. Fall Reduction Intervention Implemented note on walker to use walker. Resident is using walker currently and physical therapy. R3's Progress Notes indicated the following: -April 30, 2023, 11:19 p.m., Facility health aid calling to report R3 slid off of bed and landed in a sitting position. The fall was unwitnessed. R3 denies having any pain at this time. R3 denies hitting his head or losing consciousness. R3 denies dizziness or nausea. Skin intact. R3 maintains baseline range of motion of all four extremities. R3 was assisted back to bed with one person assist and without incident. Vital sign are as follows: blood pressure 136/74, heart rate 103, respiratory rate 18, oxygen saturation 97%, temperature 98.5. Facility health aid advised to increase safety checks per facility protocol and call triage back for any new or worsening symptoms. Incident report dated May 15, 2023, at 7:20 p.m., indicated, R3 had an unwitnessed fall in R3's living room. R3 stated he slid down and was found seated in his doorway. No injuries. Blood pressure 128/69, pulse 82, respirations 28, temperature 97, and oxygen saturation 99%. R3 was able to get up and walk at baseline with no complaints of pain or injury. Family was notified Prescriber was updated. The Incident Investigation portion of the incident report indicted R3 had a fall on April 30, 2023, and has physical therapy (PT) and occupational therapy (OT) working with him. R3 had a fractured hip a few months ago. Unsteady gait. Residents follow up and prevention environmental modifications none; assistive devices added none; and fall reduction	01620		

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01620	Continued From page 27 intervention implemented "Family aware of frequent falls. Nurses place a note on R3's walker to remind him to use the walker for all ambulation. R3's Progress Notes indicated the following: -May 15, 2023, 7:36 p.m., ULP (unlicensed personnel) called to report that R3 had a fall. R3 was seen going into his room and aide walked by and saw him sitting in his doorway. R3 states he did not fall but that he slid to the floor. Blood pressure 128/69, pulse 82, RR (respiratory rate) 28, T (temperature) 97.0 O2 (oxygen saturation) 99%. R3 was able to get up and walk at baseline with no c/o pain or injury. Call placed to son. PCP (primary care physician) updated. Request for facility nursing to complete fall follow up and care plan review. Incident report dated May 16, 2023, at 2:00 p.m., indicated, R3 had an unwitnessed fall in R3's bathroom. R3 was finished using the restroom and was attempting to pull up his pants when he fell. R3 was down on his knees in the bathroom with pants halfway down. R3 was assisted to his feet by a nurse and HHA (home health aide) using a gait belt. R3 then was escorted to a chair. No injuries. The Incident Investigation portion of the incident report indicate R3 had a previous fall on May 15, 2023. R3 is working with PT and OT. R3 got tangled in his pants using the restroom. R3 has a history of falls, gait/balance disorder, impulsive and resistive to care. Residents follow up and prevention: environmental modifications: none; assistive devices added: none; and fall reduction intervention implemented: ensure proper use of assistive device. Education to change position slowly, ensure proper footwear is available, and ensure staff are following service plan. Family aware of frequent falls.	01620		

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01620	Continued From page 28 R3's Progress Notes indicated the following: -May 16, 2023, at 2:58 p.m., R3 found in bathroom kneeling near toilet. R3 confirmed that he fell after using the restroom. Two-person assist was used to bring resident back to his feet. No injuries were found. Family notified. R3's Change of Condition Assessment dated May 24, 2023, indicated R3 required assistance with dressing, grooming, bathing, toileting per toileting schedule on service plan. R3 uses a walker for ambulation. R3 is forgetful, exhibits anxiety, and memory lost. Resident becomes angry fast and refused services. The fall risk portion of the assessment indicated resident had falls in the last three months. Mild cognitive impairment, R3 is ambulatory and incontinent. Interventions in place to prevent falls indicated "Resident has Dementia without Behaviors". Incident report dated June 1, 2023, at 5:03 a.m., indicated, R3 had an unwitnessed fall in R3's bedroom. The facility health aide called to report an unwitnessed fall. R3 was found lying next to his recliner. R3 denies hitting his head or losing consciousness. R3 appears to maintain baseline orientation. R3 denies dizziness or nausea. R3 denies pain and appears to maintain baseline range of motion of all four extremities. Blood pressure 135/67, heart rate 78, respiratory rate 20, oxygen saturation 98%, and temperature 98.2. Facility health aide was advised to use Hoyer lift with two persons assist to return R3 to his recliner or bed safely. Facility aide was also advised to increase safety checks per facility protocol and to call triage back for any new or worsening symptoms. The Incident Investigation portion of the incident report indicated the resident had a previous fall of May 16, 2023. R3	01620		

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01620	Continued From page 29 attempted self transfer. Residents follow up and prevention environmental modifications none; assistive devices added none; and fall reduction interventions implemented ensure proper use of assistive device. Education to change position slowly. Ensure staff are following service plan. Family aware of frequent falls. R3's Progress Notes indicated the following: -June 1, 2023, at 7:07 a.m., The facility health aide called to report unwitnessed fall. R3 found lying next to R3's recliner. R3 denies hitting his head or losing consciousness. R3 appears to maintain baseline orientation. R3 denies dizziness or nausea. R3 denies having any pain at this time. R3 appears to maintain baseline range of motion of all four extremities. R3's skin is intact. Vital signs are as follows: blood pressure 135/67, heart rate 78, respiratory rate 20 oxygen saturation 98%, and temperature 98.2 Facility aide was advised to use Hoyer lift with two-person assist to return R3 to recliner or bed safety. Facility health aid was also advised to increase safety checks per facility protocol and to call triage back for any new or worsening symptoms. FALL/WITNESSED Incident Report dated June 3, 2023, at 7:55 a.m., indicated, R3 had a witnessed fall in his kitchen. Staff informed resident it was time for breakfast and R3 jumped up, grabbed his walker aggressively and pushed it forward towards staff and door. R3 reached for the door and fell over his walker. R3 obtained a skin tear on his left hand. R3 was assisted off the ground into standing position. Cleaned skin tear and applied a bandage. The Incident investigation portion of the incident report indicate the resident had a previous fall on June 1, 2023. Staff check	01620		

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01620	Continued From page 30 resident on scheduled safety checks and toileting. Contributing factors include age, cognitive impairment, unsteady gait, impaired hearing, anxiety, and agitation. Residents follow up and prevention: Fall Reduction Interventions Implemented ensure proper use of assistive device, education to change positions slowly, ensure proper footwear is available, ensure staff are following service plan, and family are aware of frequent falls. R3's Progress Notes indicated the following: -June 3, 2023, at 10:57 a.m., staff went to assist resident to the dining room for breakfast. Staff said to R3 "time to go for breakfast" and R3 became upset and said "oh you want me to go to breakfast" then pushed his walker towards staff and doorway quite aggressively and as resident went through to doorway he fell over his walker. Small skin tear to left hand. No other injuries noted. No complaints of pain. Vital signs entered under health monitoring tab. Triage and family notified. (written by LPN) -June 13, 2023, at 3:28 p.m., R3 was admitted to MC (memory care today). Change of condition Assessment dated June 20, 2023, indicated R3 required assistance with dressing, grooming, bathing, toileting per toileting schedule on service plan. R3 uses a walker for ambulation. R3 uses grab bar on bed independently to transfer self out of bed. R3 is forgetful, exhibits anxiety, and memory lost. Resident becomes angry fast and refused services. The fall risk portion of the assessment indicated resident had falls in the last three months, R3 is ambulatory and incontinent. Interventions in place to prevent falls indicated "Resident has Dementia without Behaviors".	01620		

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01620	Continued From page 31 FALL/UNWITNESSED On June 21, 2023, at 11:30 a.m., R3 had an unwitnessed fall in R3's bedroom. R3 was trying to leave apartment and walk down hallway. The resident was located by staff when they went to gather R3 for lunch. No injuries. Used Hoyer lift and two people assist to return R3 to a seated position. The Incident Investigation portion of the incident report indicated the resident had a previous fall on June 3, 2023. R3 moved to Memory Care due to cognitive impairment. Resident was using a W/C (wheelchair) as a walker instead of his walker. Resident lost his balance when pushing the W/C over the threshold. W/C put in closet. Resident Follow up and Prevention: Fall Reduction Intervention Implementation: ensure proper use of assistive device, ensure proper footwear is available, ensure staff are following service plan, and family aware of frequent falls. R3's Progress Notes indicated the following: -June 21, 2023, 1:59 p.m., late entry for June 21, 2023, at 11:30 a.m., R3 fell near the threshold of his bedroom. No injuries found, no head strike. Used Hoyer lift and two-person assist to return him to a chair. Triage and family notified. Vital entered under health/fall tabs. FALL/UNWITNESSED/WITH INJURY R3's Progress Notes indicated the following: -July 10, 2023, at 4:56 a.m., R3 had an unwitnessed fall. R3 fell on the side of bed. HHA (home health aide) stated that it appears that R3 fell out of bed. R3 was unable to state fall details. HHA found R3 on a safety check. R3 did strike his head. Pupils look unequal. The right pupil looks like a keyhole appearance, which is not his normal appearance per HHA. Right sided head bump. R3 is taking blood thinners. No	01620		

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01620	Continued From page 32 complaints of pain, R3 is unsteady on feet which is unlike him. R3 has a bump to his head and skin tear to right hand. Blood pressure 195/105, heart rate 126, respirations 24, temperature 96.7, and oxygen saturation 91%. R3 got himself up prior to HHA calling triage. Triage RN (registered nurse) instructed HHA to call EMS (emergency medical service) right way due to abnormal vital signs and abnormal/unequal pupils. EMS and family called. -July 10, 2023, 7:12 a.m. - R3 was sent to the hospital. -July 10, 2023, 11:21 a.m., nurses noted R3 had a fall in R3's apartment. R3 returned to the community at 11:20 a.m. Nursing noted bruise to the left eye reaching above the eyebrow. Light blue in color. R3 has bruises to both arms, purple in color. No other noted concerns noted. R3 stated he was glad to be back. R3's Emergency Room Encounter, dated July 10, 2023, indicated reason for visit fall. Diagnoses include fall, injury of head, and skin tear of right hand without complication. R3's record lacked evidence the RN reassessed R3 for causal factors and developed fall prevention plans. On July 31, 2023, at 1:00 p.m., during the entrance conference, regional clinical director (RCD)-B stated incident reports are filled out for each fall and the fall assessment completed by the RN is on the third page of the incident report. On August 1, 2023, at 2:49 p.m., the surveyor requested an incident report for the July 10, 2023, fall and inquired if a Minnesota Adult Abuse Reporting Center (MAARC) report had been filed. At 3:16 p.m., RCD-B stated a MAARC report had not been filed for R3's unwitnessed fall with injury	01620		

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01620	Continued From page 33 on July 10, 2023. RCD-B stated the RN is to assess the resident after each fall for causal factors and develop fall prevention plans to prevent further falls. RCD-B stated the last comprehensive assessment completed by the RN was on June 20, 2023. As of August 2, 2023, at 3:00 p.m., the surveyor had not received an incident report for R3's fall on July 10, 2023. The licensee's Fall Risk and Prevention policy last revised August 2022, indicated Post Fall Procedure indicated immediately assess and treat the resident for injury. Notify nurse on site or triage nurse for evaluation prior to moving resident. If known or suspected head strike has occurred, nurse to evaluate medications, the evaluation must be completed to include notification of MD (medical doctor)/EMS (emergency medical services)/Hospice to consider evaluation at hospital. Post fall intervention implemented and add post fall service for ongoing observation. Begin the Root Cause Analysis/Review utilizing "Post Fall Huddle". Conduct interview of the resident/tenant, the first responder, the person who last saw the resident/tenant, and witnesses. Make note of the resident's/tenant's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were, and when they were provided. Review the record for medications in use, recent laboratory values, and review the plan of care to determine care provided was consistent with plan. The nurse review of the information collected, determines the root cause and initiate a plan based on the information. The plan of care is updated and revised with changes as indicated. It is critical for nursing centers and	01620		

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01620	Continued From page 34 assisted living communities to address and mitigate adverse events and potential adverse events. CHANGE OF CONDITION R3 was admitted on June 16, 2020, and transferred to the secured care unit on June 13, 2023. R3's diagnoses included Alzheimer's disease, hypertension, acute kidney disease, and fractured hip. R3's service plan dated June 20, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, oral care, toileting 9:00 a.m. and 12:00 p.m., 4:00 p.m. and 7:00 p.m., escort at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 7:00 p.m., safety checks 2:00 a.m. and 10:00 p.m. R3's Progress Notes include the following: -July 10, 2023, at 4:56 a.m., R3 had a unwitnessed fall. R3 fell on the side of bed. HHA (home health aide) stated that it appears that R3 fell out of bed. R3 was unable to state fall details. HHA found R3 on a safety check. R3 did strike his head. Pupils look unequal. The right pupil looks like a keyhole appearance, which is not his normal appearance per HHA. Right sided head bump. R3 is taking blood thinners. No complaints of pain, R3 is unsteady on feet which is unlike him. R3 has a bump to his head and skin tear to right hand. Blood pressure 195/105, heart rate 126, respirations 24, temperature 96.7, and oxygen saturation 91%. R3 got himself up prior to HHA calling triage. Triage RN (registered nurse) instructed HHA to call EMS (emergency medical service) right way due to abnormal vital signs and	01620		

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01620	Continued From page 35 abnormal/unequal pupils. EMS and family called. -July 10, 2023, 7:12 a.m. - R3 was sent to the hospital. -July 10, 2023, 11:21 a.m., nurses noted R3 had a fall in R3's apartment. R3 returned to the community at 11:20 a.m. Nursing noted bruise to the left eye reaching above the eyebrow. Light blue in color. R3 has bruises to both arms, purple in color. No other noted concerns noted. R3 stated he was glad to be back. -July 19, 2023, 6:54 a.m., HHA (Home Health Aide) calling because R3 is lethargic, seems very sleepy, seems to be slurring words this morning, and seems more confused. HHA thought R3 seemed more lethargic last night but it is worse this morning. At 5:00 a.m. when getting R3 up, was able to get up and walk to the bathroom but now he seems worse, and she doesn't believe he could walk like he did earlier. R3 is able to smile at HHA and smile seems symmetrical, no drooping seen. R3 isn't following commands as well as normal. When asked HHA stated R3 did have fall a few weeks ago that sent him to the hospital but nothing more recent. HHA states R3 is usually much more talkative that he is this morning. When asked if they have ability to grab a blood sugar, HHA states they can do it for him. No urinary issues noted recently per HHA. Triage RN call POA (power of attorney) and POA stated that she thought it would be good for R3 to be seen. POA gave her blessing to call EMS and see if R3 needs to be sent in. Triage RN stated she will call POA back with an update when available. HHA was calling EMS and will call triage back with an update. Triage nurse documented. -July 19, 2023, 7:20 a.m., Triage RN calling HHA for update. R3 was taken by EMS to hospital. R3 did test COVID positive. POA called at 7:16 a.m.	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 36 and voicemail was left. Triage RN documented calls. -July 19, 2023, at 1:37 p.m., R3 was admitted to hospital for COVID. -July 22, 2023, at 3:35 p.m., R3 returned to the community with new medication orders per his COVID and pneumonia diagnoses. R3 had several bruises on both upper extremities from IV's (hands and forearms). R3 was in good spirits initially but did have some agitation as he got settled back into the unit. Agitation was easily directed. New medication orders were processed, and new nursing assessment will be conducted. Family contacted facility and is aware of resident's condition and medication changes. R3 will be off of isolation on July 30, 3023 and nursing will monitor pneumonia via vitals and breath sound. -July 23, 2023, 6:25 a.m., facility health aid called to report R3 had increased restlessness since he returned from hospital. Facility health aide stated R3 had bandages over skin tears on his arms. However, R3 has removed bandaged repeatedly. Facility health aide states R3 has not slept tonight. Facility health aid was advised to give PRN (as necessary) Seroquel as ordered. Facility health aide to continue to monitor and call triage for any new or worsening symptoms. Needs facility RN follow up/assessment regarding wounds. -July 25, 2023, at 1:51 p.m., R3 was admitted to Hospice today. Orders in for meds. Supplies ordered and will be delivered by pharmacy. Hospice bed ordered with halo. Dressing applied to coccyx area. Resident ate poorly for breakfast and kept falling asleep during visit from hospice.	01620		

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	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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01620	Continued From page 37 -July 27, 2023, at 5:42 p.m., hospice here and assessed R3's overall status. R3's Emergency Room Encounter, dated July 10, 2023, indicated reason for visit fall. Diagnoses include fall, injury of head, and skin tear of right hand without complication. R3's Interagency Referral Form dated July 22, 2023, indicated R3's primary diagnoses was acute respiratory failure with hypoxia, COVID, altered mental status, and cognitive deficits. The referral form also indicated R3 required assistance with bathing, dressing, grooming, toileting, and standby assistance with bed mobility and transfers. The last change of condition assessment by the RN was dated June 20, 2023. On August 1, 2023, at 2:49 p.m., RCD-B stated a RN had not performed a change of condition assessment since June 20, 2023. RCD-B stated R3 was admitted to hospice on July 25, 2023. RCD-B stated the RN is to do a change of condition assessment with there is a change in conation and the assessment should be completed within seven (7) to 14 days. UNIFORM ASSESSMENT TOOL R1 R1's diagnoses included other general symptoms and signs, edema (swelling caused by excess fluid), hypertension (HTN-high blood pressure), and anxiety. R1's New Nursing Assessments were completed May 31, 2023, and June 22, 2023, respectively. On August 1, 2023, at 7:07 a.m., the surveyor	01620		

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01620	Continued From page 38 observed ULP-G complete scheduled morning medication administration to R1. R2 R2's diagnoses included hypertension, diabetes, major depressive disorder, and chronic respiratory failure. R2's New Nursing Assessment was completed May 12, 2023. On August 1, 2023, at 8:55 a.m., the surveyor observed ULP-G complete schedule morning medication administration to R2. R1 and R2's 90 Day New Nursing Assessment forms lacked the resident's personal lifestyle preferences including: spiritual and cultural preferences. On August 2, 2023, at 2:18 p.m., RCD-B stated the 90-day assessment form was used for all residents and did not include cultural and spiritual preferences. The licensee's Minnesota Clinical Assessment Guide for AL (assisted living) and MC (memory care), last reviewed August 2022, indicated nursing reassessments would be completed for change of condition/hospitalizations. The licensee's undated Minnesota Clinical Assessment Guide for AL and MC noted a nursing assessment would be done at least every 90 days using the level of care tool (uniform assessment tool). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 39 days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for three of four residents (R1, R2, R19). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01640		

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01640	Continued From page 40 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: R1 R1's diagnoses included diabetes, other general symptoms and signs, edema (swelling caused by excess fluid), hypertension (HTN-high blood pressure), and anxiety. On August 1, 2023, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a blood glucose check using a Free Style Libre on R1. R1's prescriber orders dated July 4, 2023, included an order to check blood sugar twice daily prior to breakfast and dinner. R1's New Nursing Assessment dated June 22, 2023, indicated R1 received blood glucose monitoring. R1's Service Plan dated June 23, 2023, lacked blood glucose monitoring. On August 2, 2023, at 2:15 p.m., regional clinic director (RCD)-B stated blood glucose monitoring was missing on R1's service plan. R2 R2's diagnoses included hypertension, diabetes, major depressive disorder, chronic respiratory failure, and was admitted on March 30, 2023, to the facility with a labia wound.	01640		

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01640	Continued From page 41 On August 1, 2023, at 8:55 a.m., the surveyor observed ULP-G complete scheduled morning medication administration to R2. R2's prescriber orders dated July 24, 2023, included an order for labia wound: cleanse, pat dry, xeroform, cover with small mepiplex [sic]. Home health nurse to dress twice a week and facility nurse PRN (as needed) if soiled. R2's service plan dated May 5, 2023, lacked wound care services. On August 2, 2023, at 2:31 p.m., RCD-B stated wound care was not on R2's service plan. R19 R19's diagnoses included congestive heart failure (CHF), depression, and other general symptoms and signs. R19's New Nursing Assessment dated May 23, 2023, indicated R12 wore oxygen and community unlicensed staff were responsible for the treatment. R19's Service Checkoff List dated July 1, 2023, through July 31, 2023, indicated ULPs were checking R19's oxygen use and making sure R19 was wearing device (oxygen) correctly every two hours. R19's Service Plan dated August 8, 2022, lacked oxygen management. On August 2, 2023, at 2:38 p.m., RCD-B stated oxygen management was not on R19's service plan.	01640		

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01640	Continued From page 42 The licensee's Service Plan policy dated April 2023, indicated the service plan must be reviewed, if needed, based on the results of required client (resident) monitoring and/or reassessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of four unlicensed personnel ((ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 43 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 1, 2023, at 7:12 a.m., the surveyor observed ULP-G place R1's Duoneb medication into R1's nebulizer (machine used to inhale medications) and administer R1's scheduled morning medications. ULP-G documented in R1's electronic medication administration record (EMAR) that all scheduled morning medications were administered to R1, however, R1 had not completed R1's nebulizer treatment. On August 1, 2023, at 7:37 a.m., the surveyor observed ULP-G place R12's Atrovent medication into R1's nebulizer and administer R12's scheduled morning medications. ULP-G documented in R12's EMAR that all scheduled morning medications were administered to R12, however, R12 had not completed R12's nebulizer treatment. On August 1, 2023, at 9:15 a.m., ULP-G stated both nebulizer medications were documented as administered before the resident had inhaled the medication. On August 1, 2023, at 9:33 a.m., regional clinical director (RCD)-B stated nebulizer medication should not be documented as administered until the resident has inhaled the medication. The licensee's Medications and Treatments policy	01760		

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01760	Continued From page 44 dated March 2021, indicated staff will follow the "6 rights" of medication administration including right chart/record to document that the medication was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R16). 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: During the entrance conference on July 31, 2023,	01770		

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01770	Continued From page 45 at 1:00 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services. R16's diagnoses included diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). R16's service plan dated May 23, 2023, indicated R16 received medication set up services. R16's prescriber orders dated July 10, 2023, included orders for the following: -Novolog insulin pen (a multiple dose pen shaped injector device for insulin administration) 100 units/milliliter (mL)- eight units subcutaneous (under the skin) before meals three times per day; -Levemir insulin pen 100 units/mL- 20 units subcutaneous every morning; and -Levemir insulin pen 100 units/mL- 15 units subcutaneous every night. On August 1, 2023, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-K check on R16's oxygen. R16 stated a nurse sets up R16's medications, including insulin, every week for R16. The surveyor opened R16's refrigerator and observed syringes of Novolog and Levemir. ULP-K confirmed the syringes were set up by a nurse at the facility every week. On August 1, 2023, at 12:34 p.m., registered nurse (RN)-E stated R16's refrigerator contained five Levemir syringes with 20 units insulin, eight Levemir syringes with 15 units insulin, and ten Novolog syringes with 8 units of insulin. RN-E stated the medication set ups were recorded on R16's monthly services check off list.	01770		

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01770	Continued From page 46 R16's Service Checkoff List dated July 2023, indicated "nursing to set up insulin needles for one week every Monday. Administer insulin per physician/PCP (primary care physician) order. See MAR (medication administration record) for specific medication instructions." R16's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, and route of administration. On August 2, 2023, at 2:14 p.m., regional clinical director (RCD)-B stated R16's record did not have all required content for medication set ups. The licensee's Medications and Treatments policy dated March 2021, indicated liquid medications that cannot be set up in the dosage box will be recorded on the medication administration record to include any special instructions and: a. Medication name b. Medication strength c. Dosage to be administration [sic] d. Route of administration e. Time of administration No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820		

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01820	Continued From page 47 managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of four residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Alzheimer's disease, hypertension (high blood pressure), acute kidney failure, and fractured hip. R3's service plan dated June 20, 2023, indicated R received medication management services which included medication administration daily. R3's assessment and Individualized Medication Management Plan dated June 20, 2023, noted R3 received assistance with medication management services and refer to MAR (medication administration record). R3's July 2023 MAR, indicated the following scheduled medications had been discontinued: -Hydrochlorothiazide (treat edema) 12.5 mg (milligrams) one capsule every day;	01820		

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01820	Continued From page 48 -Pantoprazole (treat acid reflex) 40 mg one tablet twice a day before meals; -Aspirin Chew (blood thinner) 81 mg, one tablet every day with food; -Atorvastatin (treat high cholesterol) 100 mg, one tablet every day with supper; -Calmoseptime ointment (moisture barrier), apply to peri-area three times daily as needed for redness; and -Quetiapine (antipsychotic) 25 mg, take 1/2 tablet (12.5 mg) daily at bedtime as needed for anxiety/agitation. R3's record contained undated Hospice orders for the discontinuing the above-mentioned medications, that were not signed by the physician. On August 2, 2023, at 10:20 a.m., regional clinical director (RCD)-B stated the Hospice orders in R3's record were not signed by the physician. RCD-B stated they were trying to contact Hospice to get signed orders. At the time of exit (3:30 p.m.) RCD-B stated Hospice had not called them back. The licensee's Medication and Treatment policy, last revised March 2021, indicated the RN (registered nurse) is responsible for assuring current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the tenants' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01880	Continued From page 49	01880		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 31, 2023, at 1:00 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents, including storage of medications. Regional clinical director (RCD)-B stated residents' medications were either stored in the medication refrigerator in the nurses' office or in the resident apartment. RCD-B stated the temperatures of the medication refrigerator in nurse's office was checked daily. The surveyor requested the temperature logs.	01880		

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01880	Continued From page 50 On August 1, 2023, at 8:55 a.m., unlicensed personnel (ULP)-G stated R2's refrigerator temperature was not monitored, and the refrigerator contained the following medications: -two (2) unopened Humulin insulin pens; and -three (3) unopened Humalog insulin pens. On August 1, 2023, at 12:34 p.m., registered nurse (RN)-E stated R16's refrigerator temperature was not monitored, and the refrigerator contained the following medications: -five (5) Levemir syringes with 20 units insulin: -eight (8) Levemir syringes with 15 units insulin; and -ten (10) Novolog syringes with 8 units of insulin. On August 1, 2023, at 9:32 a.m., RCD-B stated resident refrigerator temperatures are not monitored and would not know the current temperature of a resident refrigerator that has medications in it. On August 2, 2023, at 9:30 a.m., the surveyor and licensed practical nurse (LPN)-M observed the following medications in the medication refrigerator in the nurse's office and the medication refrigerator temperature of 38 degrees Fahrenheit (F): - five (5) Novolog FlexPens; - nine (9) Humalog insulin pens; and - three (3) epinephrine pens. On August 2, 2023, at 9:30 a.m., LPN-M stated she checks the medication refrigerator daily, but does not record the temperature. The manufacturer's instructions for Levemir dated January 2019, indicated to store Levemir Pens you are currently using out of the refrigerator	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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01880	Continued From page 51 below 86 degrees F. The FDA (Food and Drug Administration) NovoLog storage guidelines revised February 2015, indicated unopened NovoLog FlexPens should be stored in a refrigerator between 36 and 46 degrees F. The FDA Humalog storage guidelines revised March 2013, indicated unopened Humalog pens should be stored in a refrigerator between 36 and 46 degrees F. The FDA epinephrine pens guidelines revised December 2020, indicated epinephrine pens should not be refrigerated. The licensee's Medications and Treatments policy dated March 2021, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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01890	Continued From page 52 by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained with the original prescription label, including the expiration date for time sensitive medications for four of six residents (R1, R12, R14, R16). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 31, 2023, at 1:00 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents. R1 On August 1, 2023, at 7:09 a.m., the surveyor reviewed R1's medication cabinet with unlicensed personnel (ULP)-G and confirmed the following: -artificial tears 1.4% eye drops did not include the open date or expiration date; and -sodium chloride solution 5% eye drop did not include the open date or expiration date. R12 On August 1, 2023, at 7:34 a.m., the surveyor reviewed R12's medication cabinet with ULP-G and confirmed the following: -fluticasone propionate 50 micrograms (mcg)	01890		

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01890	Continued From page 53 nasal spray did not include the open date or expiration date. R14 On August 1, 2023, at 7:49 a.m., the surveyor reviewed R14's medication cabinet with ULP-G and confirmed the following: -blink tears 0.25% eye drops did not include the open date or expiration date; -Novolog 100 units/milliliter (mL) insulin pen (a multiple dose pen shaped injector device for insulin administration) did not include the open date or expiration date; and -Lantus 100 units/mL insulin pen did not include the open date or expiration date. On August 1, 2023, at 7:39 a.m., ULP-G stated inhalers, insulin pens, and eye drops should be labeled when open and when the medication would expire. R16 On August 1, 2023, at 8:15 a.m., the surveyor reviewed R16's refrigerator with ULP-K and confirmed the following: -Levemir 100 units/mL insulin syringes did not bear an original prescription label and did not include the open date or expiration date; and -Novolog 100 units/mL insulin syringes did not bear an original prescription label and did not include the open date or expiration date. On August 1, 2023, at 9:31 a.m., regional clinical director (RCD)-B stated all resident medications should contain an original prescription label and time sensitive medication should indicate the date opened and when the medication would expire. The manufacturer's instructions for Novolog insulin pens dated October 2021, directed to	01890		

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01890	Continued From page 54 discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen after 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Levemir insulin pens dated January 2019, directed to discard the pen 42 days after it had been opened, even if it still had insulin left in it. The licensee's Medications and Treatments policy dated March 2021, indicated medications must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration date. In addition, the medication expiration date of a product (medication) can change once it is opened: -eye drops expired 28 days from date when opened; -flovent inhaler expired 42 days from date when opened; and -insulin expired 28 days after vial/pen opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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01940	Continued From page 55 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R2) who had treatment or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01940		

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01940	Continued From page 56 cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 31, 2023, at 1:00 p.m., regional clinical director (RCD)-B stated the licensee provided treatment services to residents. R1 R1's diagnoses included diabetes, other general symptoms and signs, edema (swelling caused by excess fluid), hypertension (HTN-high blood pressure), and anxiety. R1's prescriber orders dated July 4, 2023, included an order to check blood sugar twice daily prior to breakfast and dinner. R1's New Nursing Assessment dated June 22, 2023, indicated R1 received blood glucose monitoring. On August 1, 2023, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a blood glucose check using a Free Style Libre on R1. R1's service plan dated September 23, 2023, lacked a written statement of the treatment of services the resident received to include blood glucose being checked two times daily. R1's record lacked evidence of an individualized treatment or therapy management plan which	01940		

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01940	Continued From page 57 included the following: -a statement of services that would be provided; -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 2, 2023, at 2:15 p.m., RCD-B stated R1's record did not have a treatment plan with the required content relating to blood glucose monitoring. R2 R2's diagnoses included hypertension, diabetes, major depressive disorder, and chronic respiratory failure. R2's prescriber orders dated July 24, 2023, included an order for labia wound: cleanse, pat dry, xeroform, cover with small mepiplex [sic]. Home health nurse to dress twice a week and facility nurse PRN (as needed) if soiled. On August 1, 2023, at 8:55 a.m., the surveyor observed ULP-G complete scheduled morning medication administration to R2. R2's service plan dated May 5, 2023, lacked wound care services provided twice weekly and as needed if the wound dressing was soiled. R2's record lacked evidence of an individualized	01940		

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01940	Continued From page 58 treatment or therapy management plan which included the following: -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 2, 2023, at 2:31 p.m., RCD-B stated R2's record lacked the required content regarding R2's wound care treatment plan. The licensee's Medications and Treatments policy dated March 2021, indicated the medication and treatment management plan would include the following: - describe the medication or treatment service provided; -documentation of tenant (resident) specific instructions for medications or treatments; -identify which medications or treatments are delegated to unlicensed personnel; -identify the procedure for notifying the registered nurse or other licensed staff when a problem arises; -the plan will identify tenant specific instructions for documenting medication or treatment administration verification; and -be kept current and updated with any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 59 days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse (RN) for one of one unlicensed personnel ((ULP)-G). 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	01950		

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01950	Continued From page 60 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-G was hired October 21, 2022, to provided assisted living services to residents at the facility. R1's Service Checkoff List for July 2023, indicated on July 3, 4, 5, 7, 8, 9, 10, 11, 13, 17, 18, 19, 21, 22, 23, 24, 25, and 31, 2023, ULP-G cleaned the surface of the mask cushion/pillows with soapy cloth or mask wipes on R1's continuous positive airway pressure (CPAP) machine. R1's Service Checkoff List for July 2023, indicated on July 3, 4, 5, 7, 8, 9, 10, 11, 13, 17, 18, 19, 21, 22, 23, 24, 25, and 31, ULP-G ensured R1 was wearing oxygen via nasal cannula at 3 liters per minute (LPM). R2's Service Checkoff List for July 2023, indicated on July 9, ULP-G cleansed R2's wound with wound cleanser and applied a new dressing. ULP-G's employee record lacked evidence to indicate ULP-G was trained and demonstrated competency to an RN to manage R1's CPAP and oxygen. In addition, the record lacked evidence to indicate ULP-G was trained and demonstrated competency to an RN to complete R2's wound care. On August 2, 2023, at 2:10 p.m., licensed assisted living director (LALD)-A stated ULP-G record lacked competency testing completed by an RN for oxygen, CPAP, and wound care.	01950		

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	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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01950	Continued From page 61 The licensee's Nursing Services policy dated March 2021, indicated a RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the client (resident). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of three residents (R1) with treatments managed by the provider.	01960		

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01960	Continued From page 62 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 July 31, 2023, at 1:00 p.m., regional clinical director (RCD)-B stated the licensee provided treatment services to residents. R1's diagnoses included other general symptoms and signs, edema (swelling caused by excess fluid), hypertension (HTN-high blood pressure), and anxiety. R1's service plan, dated June 23, 2023, indicated services included assistance with bathing, dressing, medication administration, oxygen management, continuous positive airway pressure (CPAP) management, and laundry. R1's Physician Order Sheet dated July 4, 2023, indicated CPAP clean the surface of the mask cushion/pillows with soapy cloth or CPAP mask wipes daily. R1's NEW Nursing Assessment dated June 22, 2023, indicated R1 wore a CPAP and was managed by community licensed staff and community unlicensed staff. R1's Service Checkoff List dated July 1, 2023, through July 31, 2023, indicated to clean the	01960		

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01960	Continued From page 63 surface of the mask cushion/pillows with soapy cloth or CPAP mask wipes daily at 8:00 a.m. This service was documented at complete 31 times out of 31 opportunities. On August 1, 2023, at 7:07 a.m., the surveyor observed unlicensed personnel (ULP)-G complete scheduled morning medication administration to R1. On August 1, 2023, at 7:15 a.m., R1 stated staff does not clean R1's CPAP machine. On August 1, 2023, at 1:35 p.m., ULP-G stated staff do not clean R1's CPAP machine on the day shift. On August 2, 2023, at 2:17 p.m., RCD-B stated ULPs should be cleaning R1's CPAP if the instructions on the service checkoff list indicated to do so daily. The licensee's Medications and Treatments policy dated March 2021, indicated all treatment to be administered as prescribed and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 64 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 written or electronically recorded orders were maintained for one of three residents (R1) who received treatments managed by the provider. 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: During the entrance conference on July 31, 2023, at 1:00 p.m., regional clinical director (RCD)-B stated the licensee provided treatment services to residents. R1's diagnoses included other general symptoms and signs, edema (swelling caused by excess fluid), hypertension (HTN-high blood pressure), and anxiety. R1's service plan, dated June 23, 2023, indicated services included assistance with bathing, dressing, medication administration, oxygen management, and laundry. On August 1, 2023, at 7:07 a.m., the surveyor observed unlicensed personnel (ULP)-G	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

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01970	Continued From page 65 complete scheduled morning medication administration to R1. R1's Physician Order Sheet dated July 4, 2023, included the following orders: -oxygen two (2) LPM (liters per minute) daytime and at night; and -oxygen per NC (nasal cannula-a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) three liters. R1's record lacked a clarification order to administer the correct flow of oxygen. On August 2, 2023, at 2:30 p.m., RCD-B stated R1's oxygen order should have been clarified to know the correct rate the oxygen should be administered at. The licensee's Medications and Treatments policy dated March 2021, indicated the registered nurse (RN) is responsible for assuring current, authorized prescriber orders for medication or treatments administered by the staff are kept on fil in the tenants' (resident) records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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THE LEGACY OF DELANO	1350 ST. PETER AVENUE EAST DELANO, MN 55328

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03000	Continued From page 66 immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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03000	Continued From page 67 subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for one of one resident (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 R3's diagnoses included Alzheimer's disease, hypertension, acute kidney disease, and fractured hip. R3's service plan dated June 20, 2023, indicated R3 received assistance with medication administration, bathing, dressing, grooming, oral care, and toileting. R3's Progress Notes indicated the following: -July 10, 2023, at 4:56 a.m., R3 had a unwitnessed fall. R3 fell on the side of bed. HHA (home health aide) stated that it appears that R3	03000		

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	29189	A. BUILDING: _____ B. WING _____	08/02/2023

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03000	Continued From page 68 fell out of bed. R3 was unable to state fall details. HHA found R3 on a safety check. R3 did strike his head. Pupils look unequal. The right pupil looks like a keyhole appearance, which is not his normal appearance per HHA. Right sided head bump. R3 is taking blood thinners. No complaints of pain, R3 is unsteady on feet which is unlike him. R3 has a bump to his head and skin tear to right hand. Blood pressure 195/105, heart rate 126, respirations 24, temperature 96.7, and oxygen saturation 91%. R3 got himself up prior to HHA calling triage. Triage RN (registered nurse) instructed HHA to call EMS (emergency medical service) right way due to abnormal vital signs and abnormal/unequal pupils. EMS and family called. -July 10, 2023, 7:12 a.m. - R3 was sent to the hospital -July 10, 2023, 11:21 a.m., nurses noted R3 had a fall in R3's apartment. R3 returned to the community at 11:20 a.m. Nursing noted bruise to the left eye reaching above the eyebrow. Light blue in color. R3 has bruises to both arms, purple in color. No other noted concerns noted. R3 stated he was glad to be back. R3's Emergency Room Encounter, dated July 10, 2023, indicated reason for visit fall. Diagnoses include fall, injury of head, and skin tear of right hand without complication. On August 1, 2023, at 2:49 p.m., the surveyor requested a incident report for the July 10, 2023, fall and if a MAARC report had been filed. at 3:16 p.m. regional clinical director (RCD)-B stated a MAARC report had not been filed for R3's unwitnessed fall with injury on July 10, 2023. In addition, RCD-B also stated a MAARC report should of been completed. As of August 2, 2023, at 3:00 p.m., the surveyor	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 69 had not received a incident report for R3's fall on July 10, 2023. The licensee's Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting policy last revised October 2022, indicated all Facility staff shall immediately make a report to MAARC if the reporter has reason to believe that the vulnerable adult has sustained an injury which is not explained. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/01/23*
Time: 15:38:47
Report: 7930231140

Food and Beverage Establishment Inspection Report

Location:
The Legacy Of Delano
1350 St. Peter Avenue East
Delano, MN55328
Wright County, 86

Establishment Info:
ID #: 0038968
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7639722333
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.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

TURKEY HAM DATED 7/31 IN PREP COOLER.

Comply By: 08/01/23

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.

A CHLORINE TEST KIT WAS NOT AVAILABLE IN THE MEMORY CARE SERVING KITCHEN. PROVIDE CHLORINE TEST STRIPS TO MONITOR THE SANITIZING CYCLE OF THE DISHWASHER.

Comply By: 08/08/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE VULCAN STEAMER AND TRUE UPRIGHT COOLER ON COOKLINE ARE BOTH OUT OF ORDER AND WERE NOT FUNCTIONING AT TIME OF INSPECTION. REPAIR TO WORKING CONDITION.

Comply By: 08/11/23

Type: Full
Date: *08/01/23*
Time: 15:38:47
Report: 7930231140
The Legacy Of Delano

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Lactic Acid: = 704PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET IN KITCHEN
Violation Issued: No

Hot Water: = at 161.1 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE--KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 169 Degrees Fahrenheit - Location: BEEF TIPS IN GRAVY
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 37 Degrees Fahrenheit - Location: SLICED TOMATOES
Violation Issued: No

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

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

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: SPANISH RICE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK--MEMORY CARE SERVING KITCHEN
Violation Issued: No

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

DISCUSSION ITEMS:
-EMPLOYEE ILLNESS LOG
-DATE MARKING--FACT SHEET EMAILED WITH REPORT

Type: Full
Date: *08/01/23*
Time: 15:38:47
Report: 7930231140
The Legacy Of Delano

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 7930231140 of 08/01/23.

Certified Food Protection Manager: CARLA M. PHILLIPS

Certification Number: 115795 Expires: 03/30/26

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us