Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 3, 2023

Licensee
Lewiston Senior Living
505 East Main Street
Lewiston, MN 55952

RE: Project Number(s) SL33311015

Dear Licensee:

On September 22, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 3, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 3, 2023 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 3, 2023, found not corrected at the time of the September 22, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1)
2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on September 22, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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.

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

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at jessie.chenze@state.mn.us.

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

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	R 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33311015-1 On September 20, 2023, through September 22, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 3, 2023. At the time of the survey, there were 23 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, correction order 0780 and 2310 were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}		

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{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}		

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 250}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	{0 510}		

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{0 510}	Continued From page 3 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: No further action required.	{0 510}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required.	{0 640}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	{0 650}		

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{0 650}	Continued From page 4 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	{0 660}		

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{0 660}	Continued From page 5 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to 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.	{0 680}		

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{0 680}	Continued From page 6	{0 680}		
	This MN Requirement is not met as evidenced by: No further action required.			
{0 780} SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}		
	(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;			
	This MN Requirement is not met as evidenced by: Based on document review, the licensee failed to provide a smoke alarm in a resident's sleeping room. This deficient condition had the potential to affect a limited number of staff, residents, and			

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{0 780}	Continued From page 7 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On September 20, 2023, survey staff emailed the registered nurse/owner (RN/O)-C requesting documentation to support that a smoke alarm had been installed in resident sleeping room 34. On September 22, 2023, the RN/O-C emailed that a smoke alarm had not been installed yet. A service provider had been onsite September 1, 2023, and had ordered the parts needed to complete this smoke alarm installation. Work order communications were also provided for review. The service provider confirmed on September 20, 2023, that the parts had been delivered and they would be scheduling this smoke alarm installation soon.	{0 780}		
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	{0 950}		

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{0 950}	Continued From page 8 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action required.	{0 950}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment;	{01370}		

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{01370}	Continued From page 9 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	{01380}		

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{01380}	Continued From page 10 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required.	{01380}		
{01440} SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	{01440}		

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{01440}	Continued From page 11 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action required.	{01440}		
{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 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	{01470}		

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{01470}	Continued From page 12 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, 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: No further action required.	{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	{01540}		

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	33311	A. BUILDING: ____ B. WING ____	R 09/22/2023

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{01540}	Continued From page 13 specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01540}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	{01620}		

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{01620}	Continued From page 14 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: No further action required.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for 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.	{01640}		

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{01640}	Continued From page 15 This MN Requirement is not met as evidenced by: No further action required.	{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: No further action required.	{01760}		
{01770} SS=F	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: No further action required.	{01770}		

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{02110}	Continued From page 16	{02110}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	{02110}		

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{02110}	Continued From page 17	{02110}		

This MN Requirement is not met as evidenced by:
No further action required.

{02310} SS=D — 144G.91 Subd. 4 (a) Appropriate care and services — {02310}

(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R8) with a hospital bedrail.

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:

R8's diagnoses included chronic kidney disease and diabetes mellitus type II.

On September 20, 2023, at 1:58 p.m.,the surveyor reviewed R8's medical record to include a hospital bed with bilateral bedrails.

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{02310}	Continued From page 18 R8's Service Plan dated August 25, 2023, indicated R8 required assistance with medication administration, grooming, dressing, escorts, incontinence care, bathing, behavior monitoring, meal setup, housekeeping and laundry. R8's Side Rail Use Assessment Form dated August 21, 2023, indicated R8 made attempts to get out of bed without asisstance, had periods of agitation and confusion, had a history of falls from his bed, had poor trunk control and difficulty sitting on the side of the bed. R8's assessment indicated bilateral bedrails were recommended following a physical therapy (PT) evaluation and would be used for positioning and support. Additionally, the assessment indicated family had requested the bedrails and risks/benefits of having the bedrails had been verbally reviewed with the family. R8's Clinical Update assessments dated August 24, 2023, (post fall assessment), August 26, 2023, (addition of activities preference), August 29, 2023, (post fall assessment) and September 15, 2023, (physician visit), respectively, included a section titled Safety. The Safety section indicated R8 did not have bedrails and was awaiting a PT evaluation. The PT evaluation had been completed and bilateral bedrails installed on August 21, 2023. R8's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones pertaining to the use of the device and a physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. On September 20, 2023, at 3:24 p.m., registered	{02310}		

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{02310}	Continued From page 19	{02310}		

nurse/owner (RN/O)-C stated the facility had provided R8's hospital bed and RN/O-C had removed the bedrails at time of admission on August 14, 2023, pending a PT evaluation for need. The PT evaluation completed on August 21, 2023, had resulted in a recommendation to have bedrails and RN/O-C had reinstalled the bedrails on the hospital bed. RN/O-C stated she did not feel she needed to measure the hospital bedrails because, "the bed had already been in a staged room and we had used the bed previously, so I just knew it was fine with measurements". The surveyor asked if measurements and/or stability had been included in R8's assessments and RN/O-C stated, "there are no measurements on it".

The licensee's Side Rails policy dated May 1, 2022, indicated when the licensee was aware of a resident utilizing bedrails, licensee would assess, educate the resident, when appropriate, the responsible person regarding risks vs benefits, verify the design is safe, utilized consistent with manufacture directions, bedrails are installed securely, in good operating condition, bedrails are consistent with dimensional measurement to reduce entrapment and the policy would be followed regardless of who owns or supplied the bedrails.

The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep

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{02310}	Continued From page 20 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 20, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail	{02310}		

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{02310}	Continued From page 21 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information provided.	{02310}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 22, 2023

Licensee
Lewiston Senior Living
505 East Main Street
Lewiston, MN 55952

RE: Project Number(s) SL33311015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 3, 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

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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: SL33311015 On July 31, 2023, through August 3, 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 22 active residents; 19 receiving services under the Assisted Living with Dementia Care license. 2310: An immediate order was identified on August 1, 2023. Although the immediacy was lifted, the order remains at a level 3, isolated (G).	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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	33311	A. BUILDING: ____ B. WING ____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the commissioner;
(13) violates any local, city, or township ordinance relating to housing or assisted living services;
(14) has repeated incidents of personnel performing services beyond their competency level; or
(15) has operated beyond the scope of the assisted living facility's license category.
(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.

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

The findings include:

During the entrance conference on July 31, 2023, at 11:45 a.m. registered nurse/owner (RN/O)-C

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and clinical nurse supervisor (CNS)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.

The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:

- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.

- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.

- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.

- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.

- Reporting of Maltreatment of Vulnerable Adults.

- Electronic Monitoring in Certain Facilities.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which

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may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all

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attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.

- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.

Page five was electronically signed by RN/O-C on May 31, 2022.

The licensee had an assisted living license issued on August 1, 2022, with an expiration date of September 30, 2023.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;
(2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
(3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;
(4) orientation to and implementation of the assisted living bill of rights;
(5) infection control practices;
(6) conducting appropriate screenings, or

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0 250	Continued From page 6 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (7) medication and treatment management; (8) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0510, 0640, 0650, 0660, 1370, 1380, 1440, 1470, 1540, 1620, 1760, 1770, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480		

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0 480	Continued From page 7 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 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-D, ULP-F) observed while providing cares. This had the potential to affect all residents.	0 510		

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0 510	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D On August 1, 2023, at 7:45 a.m., the surveyor observed ULP-D without sanitizing or washing hands put on gloves, open the medication cart, remove R4's medications, and compare the medications to the orders in the computer. After each medication was compared to the order, ULP-D punched the medication out of the foil back card into a medication cup. After each medication was removed from the card, ULP-D used a pen to initial the card, and then marked on the computer that she had "prepped and verified" the medication. Once all medications were prepared in the cup, she put the medication cards back into the medication cart, shut the drawer and locked it. Wearing the same gloves, ULP-D carried the medication cup to R4's room, knocked on the door and opened it. ULP-D was observed to administer the medications to R4, and using the same gloved hands, applied R4's TED (thrombo-embolic deterrent) socks (compression socks used to increase circulation to prevent swelling) to his left leg. ULP-D then opened the door of the room and walked out of R4's room. ULP-D was observed to touch her hair (tied back into a ponytail), chin of her face, and then reached into her front pocket to obtain the	0 510		

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medication cart keys while wearing the same gloved hands. ULP-D documented the administration of the medications on the computer, and then removed her gloves. ULP-D did not wash or sanitize her hands after removing the gloves.

ULP-F
On August 1, 2023, at 7:45 a.m. ULP-F (already wearing gloves) accompanied ULP-D and the surveyor into R4's room. ULP-F was observed to make R4's bed and then apply a TED stocking to R4's right leg. After R4's TED stocking was applied, ULP-F removed her gloves, disposed of into the garbage, and left the room. ULP-F did not sanitize or wash her hands.

On August 1, 2023, at 7:51 a.m. the surveyor observed ULP-F put on gloves without washing or sanitizing her hands, pick up the laptop computer from the medication cart, enter a code on the secured unit door keypad, and entered the unit with the surveyor. Wearing the same gloved hands, ULP-F reached into her pocket and took the keys out to open the locked drawer containing the medications. ULP-F removed R3's medication cards and compared each medication with the order on the computer. After each medication was compared to the order, ULP-F punched the medication out of the foil backed card and placed into a medication cup. After each medication was removed from the card, she used a pen to initial the card and then mark "prepped and verified" on the computer screen. ULP-F was observed to administer the medications to R3. Wearing same gloves, ULP-F closed the lid on the laptop computer, reached back into her pocket to obtain the keys, and locked the medication drawer. ULP-F then removed and disposed of her gloves and

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proceeded to leave the secured unit by entering the code on the door keypad. ULP-F did not wash or sanitize her hands.

On August 1, 2023, at 7:59 a.m. ULP-F stated she performed hand hygiene "as much as I remember". ULP-F further stated hands should be washed or sanitized before and after wearing gloves, acknowledging she had not done so.

On August 1, 2023, at 8:30 a.m. ULP-D stated she was trained and should have completed hand hygiene after removing gloves or doing any personal care tasks.

On August 3, 2023, at 9:50 a.m., registered nurse/owner (RN/O)-C stated hand hygiene should be performed before and after direct resident cares and before and after glove use.

The licensee's 8.07 Gloves policy dated revised May 1, 2022, noted:
1. Wash hands
2. Apply gloves to both hands
3. Remove contaminated materials
4. Place materials in proper receptacle
5. Remove gloves
6. Dispose used gloves in proper receptacle
7. Rewash/sanitize hands

The licensee's 8.09 Hand Washing policy dated revised May 1, 2022, noted:
-Hand washing would be completed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross-contaminations.
-When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves.

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0 510	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone number for 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 640		

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0 640	Continued From page 12 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the facility tour on July 31, 2023, at 11:45 a.m. the surveyor observed the entry and common areas within the facility with clinical nurse supervisor (CNS)-B and noted there was no posting of the 911 emergency number as required. On July 31, 2023, at 3:00 p.m. registered nurse/owner (RN/O)-C verified the 911 emergency number was not posted. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated May 1, 2022, noted the facility would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:
(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;
(2) records of orientation, required annual training and infection control training, and competency evaluations;
(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;
(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;
(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and
(6) documentation of the background study as required under section 144.057.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-D).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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

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0 650	Continued From page 14 situation has occurred only occasionally). The findings include: ULP-D started employment on July 21, 2022. On August 1, 2023, at 7:45 a.m. ULP-D was observed to administer medications to R4. ULP-D's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On August 3, 2023, at 10:42 a.m. registered nurse/owner (RN/O)-C verified the above content was missing from ULP-D's employee record. The licensee's 4.35 Employee Evaluation policy dated May 1, 2022, indicated all staff of the licensee would be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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
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include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.
(b) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-D, 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee's TB risk assessment dated January 28, 2023, indicated the licensee was a low risk.

ULP-D
ULP-D was hired July 21, 2022, to provide direct care services.

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On August 1, 2023, at 7:45 a.m. ULP-D was observed to administer medications to R4.

ULP-D's employee record contained a negative Interferon Gamma Release Assay (IGRA) (serum blood test) dated June 23, 2022; however, ULP-D's employee record lacked evidence of the following:
- TB history and symptom screening

ULP-G
ULP-G was hired May 30, 2023, to provide direct care services.

ULP-G's employee record contained a negative one step tuberculin skin test (TST) dated May 25, 2023; however, ULP-G's employee record lacked evidence of the following:
- second step TST
- TB history and symptom screening

On August 3, 2023, at 10:40 a.m. registered nurse/owner (RN/O)-C stated ULP-D and ULP-G's employee files were missing the above listed content.

The licensee's 8.16 Tuberculosis Screening revised May 1, 2022, identified the licensee would maintain a TB prevention and control program based on the most current guidelines issued by the CDC. The policy further included:
Screening will be conducted as follows:
1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for health care workers.
2. New staff will be tested by an IGRA blood test or two-step Mantoux

The Minnesota Department of Health (MDH)

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0 660	Continued From page 17 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to 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	0 680		

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available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, have a written emergency preparedness (EP) plan with all the required content, and evaluate its missing person policy at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility.

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

The findings include:

EMERGENCY PLAN POSTED
On July 31, 2023, at 12:52 p.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor observed there was no signage posted or information regarding the licensee's emergency preparedness plan. Except for posting of emergency exits, there was nothing regarding an emergency preparedness plan that was posted or displayed in the facility's main entrance area.

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0 680	Continued From page 19 On July 31, 2023, at 2:32 p.m. registered nurse/owner (RN/O)-B stated the emergency preparedness book was kept in the maintenance office and business/nursing office. RN/O-B verified the emergency preparedness plan was not posted prominently. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's undated, emergency preparedness plan titled Disaster & Emergency Manual, lacked signatures or an annual date of review. The binder contained fire drill documents, an evacuation plan, emergency shutdown valve pictures, and various policies and procedures. However, the plan lacked the following required content: - Hazard vulnerability assessment; - Policies and procedures for volunteers; - Emergency officials' contact information to include the Office of Ombudsman for long term care (LTC); - Facilities role in providing care and treatment at alternative sites under a 1135 waiver; - Emergency prep testing requirements. MISSING RESIDENT PLAN/POLICY The licensee's 2.28 Missing Resident policy was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On August 3, 2023, at 11:00 a.m. RN/O-B stated the emergency plan was missing content to the EP plan and the missing resident plan had not been reviewed every quarter. RN/O-B stated she was not aware of the requirements.	0 680		

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0 680	Continued From page 20 The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated May 1, 2022, identified the emergency preparedness plan would be in writing and reviewed annually. The plan would be based on the assisted living-based and community-based risk assessments, utilizing an all-hazards approach. The licensee's EP plan would include policies and procedures designed to align with the requirements in appendix Z. In addition, the policy identified the licensee would conduct, at minimum, two emergency preparedness drills every 12 months. One annual exercise would be a full-scale community wide exercise and the second annual exercise would either be a second full-scale community-wide exercise, or a tabletop exercise focused on the assisted living setting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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0 780	Continued From page 21 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On August 1, 2023, between 1:25 p.m. and 3:00 p.m., survey staff toured the facility with maintenance manager (MM)-E. During the facility tour, survey staff observed that a smoke alarm was not installed in resident sleeping room 34. This deficient condition was verified by MM-E	0 780		

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0 780	Continued From page 22 accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include:	0 800		

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0 800	Continued From page 23 On August 1, 2023, between 1:25 p.m. and 3:00 p.m., survey staff toured the facility with maintenance manager (MM)-E. During the facility tour, survey staff observed the following: 1. A marked exit door was sticking, making it difficult to open in an employee-only area. 2. There was a hole in the wall in a storage room on the main floor. 3. A tin can stored next to the building was being used for burnt used cigarettes on the patio used by employees. The listed disposal container provided for burnt cigarettes was in disrepair. These deficient conditions were verified by MM-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).

Findings include:

On August 1, 2023, between 1:25 p.m. and 3:00 p.m., survey staff toured the facility with maintenance manager (MM)-E. During the facility tour, survey staff observed a patio surrounded by a fence for the dementia care area. The door leading to this patio had an exit sign posted over it and a key-only padlock was provided at the fence gate. MM-E explained during the tour that the key for the padlock was available to the employees working in the dementia care area. All paths of egress must be maintained to allow occupants to exit the building in a safe and efficient manner in the event of an emergency.

This deficient condition was verified by MM-A accompanying on the facility tour.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 950	Continued From page 25	0 950		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for the right to a designated representative on a document separate from the contract and failed to ensure the contract	0 950		

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included the required content for two of two residents (R3, R4).

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R3's Assisted Living Agreement (contract) was signed by registered nurse/owner (RN/O)-C and R3's designated responsible person and/or legal representative on April 1, 2022.

R4's Assisted Living Agreement was signed by a community representative and R4 on July 30, 2021.

The fourth page of R3's Assisted Living Agreement and third page of R4's Assisted Living Agreement contained the following paragraph:
5. Designated Representative. As a resident in an Assisted Living Facility, you have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact") or health care power of attorney ("health care agent"). If you wish to have a Designated Representative, please list their contact information below.
Below the paragraph was a line for a designated

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0 950	Continued From page 27 representative to be listed; however, R3 and R4's records lacked evidence in writing of providing the verbatim notice on a document separate from the contract as required. In addition, R3 and R4's Assisted Living Agreement lacked the required box the resident must initial if the resident declines to name a designated representative as part of the contract as required. On August 3, 2023, at 10:03 a.m. RN/O-C stated R3 and R4's contract and record lacked the required content as listed above. In addition, RN/O-B stated the licensee's contract would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01370		

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01370	Continued From page 28 devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or	01370		

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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
01370	Continued From page 29 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G had a hire date of May 30, 2023, to provide direct care services. ULP-G's record lacked evidence the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the provider; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk for falls; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and clients and the client's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On August 2, 2023, at 11:39 a.m. registered nurse/owner (RN/O)-C verified the above topics were lacking from ULP-G's employee file. RN/O-C stated the courses had been assigned, but ULP-G had not completed them.	01370		

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01370	Continued From page 30 The licensee's 5.02 Competency Training Evaluations policy dated May 1, 2022, included training for all ULP's would include the above missing topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed personnel (ULP-G). This practice resulted in a level two violation (a	01380		

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01380	Continued From page 31	01380		

Continued From page 31

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-G had a hire date of May 30, 2023, to provide direct care services.

ULP-G's employee record lacked evidence to indicate the employee's completed training and/or practical skills evaluations as required in the following areas prior to providing direct care services:
- observation, reporting, and documenting of client status;
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and
- recognizing physical, emotional, cognitive, and developmental needs of the client;

On August 2, 2023, at 11:39 a.m. registered nurse/owner (RN/O)-C verified the above topics were lacking from ULP-G's employee file. RN/O-C stated the courses had been assigned, but ULP-G had not completed them.

The licensee's 5.02 Competency Training Evaluations policy dated May 1, 2022, included training for all ULP's would include the above missing topics.

No further information was provided.

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01380	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of two of two unlicensed personnel (ULP-D, ULP-G) performing delegated nursing or therapy tasks within 30 days of first providing	01440		

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01440	Continued From page 33 those 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 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: ULP-D ULP-D was hired on July 21, 2022, to provide direct care services. On August 1, 2023, at 7:45 a.m. ULP-D was observed to administer medications to R4. ULP-D's employee record lacked documentation of a RN supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. ULP-G ULP-G was hired May 30, 2023, to provide direct care services. ULP-G's employee record lacked documentation of a RN supervising ULP-G performing delegated tasks within 30 days of beginning work with the licensee. On August 3, 2023, at 10:46 a.m. registered nurse/owner (RN/O)-C stated both ULP-D and ULP-G provided delegated tasks and stated their employee file lacked a 30-day supervision of	01440		

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01440	Continued From page 34	01440		

delegated tasks.

The licensee's 6.17 Supervision of Staff - Delegated Services policy dated revised May 1, 2023, identified:
1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [The Licensee] and first performs the delegated tasks, independently, for residents and thereafter as needed based on performance.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01470 SS=D — 144G.63 Subd. 2 Content of required orientation — 01470

(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 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;

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01470	Continued From page 35 (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, 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 one of two unlicensed	01470		

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01470	Continued From page 36	01470		

personnel (ULP-G) received orientation to assisted living facility licensing requirements and regulations before providing 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:

ULP-G was hired on May 30, 2023, to provide direct care services to the licensee's residents.

ULP-G's employee record lacked evidence of receiving orientation to assisted living to include the following required content:
- 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

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01470	Continued From page 37	01470		

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 11:39 a.m. registered nurse/owner (RN/O)-C stated the orientation requirements had been assigned to ULP-G upon hire, but he had not completed it.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.

01540 SS=D — 01540

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

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01540	Continued From page 38 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for one of two employees (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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an assisted living with dementia care license dated August 1, 2022. ULP-G had a hire date of May 30, 2023, to provide direct care services. ULP-G's employee record contained no evidence of training on dementia care topics within 80 working hours of the start date. On August 3, 2023, at 10:46 a.m. registered nurse/owner (RN/O)-C stated ULP-G had worked 197 hours to date. RN/O-C stated ULP-G lacked	01540		

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01540	Continued From page 39 the required eight hours of dementia training within 80 working hours. The licensee's 5.03 Dementia Training policy dated May 1, 2022, noted direct-care employees would complete eight hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 40 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's record lacked evidence that a service plan had been developed. R3's last two assessments were requested. Assessments dated January 26, 2023, and June 28, 2023, were provided. The June 28, 2023, assessment was 153 days after the last date of the assessment, exceeding 90 calendar days. R4 R4's Service Plan dated July 17, 2023, indicated R4 received services including medication management, assistance with compression stockings, international normalized ratio (INR) checks (how long it takes blood to clot), blood sugar checks, laundry, and light housekeeping.	01620		

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01620	Continued From page 41 R4's last two assessments were requested. Assessments dated March 12, 2023, and July 20, 2023, were provided. The July 20, 2023, assessment was 130 days after the date of the previous assessment, exceeding 90 calendar days. On August 1, 2023, at 3:45 p.m. clinical nurse supervisor (CNS)-B stated R3 and R4's assessments were greater than 90 days apart. CNS-B stated their computer system had a tracking mechanism, but these were "missed". The licensee's 6.01 Assessments, Reviews & Monitoring policy dated revised May 1, 2022, identified ongoing resident reassessments 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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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 one of two residents' (R3) service plans were developed and implemented.

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 record lacked evidence that a service plan had been developed.

R3's diagnoses included coronary artery disease (condition where the major blood vessels supplying the heart are narrowed), diabetes mellitus (a condition that affects the way the body processes blood glucose), hypertension (high

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01640	Continued From page 43	01640		

blood pressure), Lewy body dementia (changes in thinking, memory, and movement abilities) and schizophrenia (mental disorder in which people interpret reality abnormally).

R3's Care Plan dated June 28, 2023, indicated the resident received medication administration.

On August 1, 2023, at 7:51 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R3.

On August 3, 2023, at 11:50 a.m. registered nurse/owner (RN/O)-C stated R3 did not have a service plan developed and implemented as required.

The licensee's 6.08 Service Plan policy dated revised May 1, 2022, noted all residents receiving assisted living services will have a service plan in place. Other optional documents such as "care plans", "assignment sheets", or other internal documents may be used to assist staff in understanding their daily assignments and tasks, but such documents are not required and do not replace the required service plan.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

01760 SS=D — 144G.71 Subd. 8 Documentation of administration of medication — 01760

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	**505 EAST MAIN STREET LEWISTON, MN 55952**

(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
01760	Continued From page 44 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included atrial fibrillation (abnormal heart rhythm), vitamin B-12 deficiency, and congestive heart failure (heart disease that affects pumping action of the heart muscles). R4's Service Plan dated July 17, 2023, and signed by R4, indicated R4 received medication administration. R4's medication administration record (MAR)	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ____ B. WING ____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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
01760	Continued From page 45	01760		

Continued From page 45

dated July 2023, included vitamin B-12 (supplement) 1000 microgram (mcg) tablet by mouth every morning.

R4's physician orders dated May 24, 2023, included vitamin B-12 1000 mcg tablet by mouth every morning.

On August 1, 2023, at 7:45 a.m. unlicensed personnel (ULP)-D was observed to prepare R4's scheduled morning medications. ULP-D compared each medication card to the order in the computer. R4's vitamin B-12 card lacked a dosage. ULP-D stated the licensed practical nurse (LPN) checks the medications for R4 and proceeded to punch the medication out of the foil backed card into the medication cup. ULP-D then administered the medications to R4.

On August 1, 2023, at 3:14 p.m. clinical nurse supervisor (CNS)-B stated LPN-H set up R4's medications from pharmacy bottles into the foil backed cards and wrote the required information on the medication label. CNS-B stated ULP-D should have notified a nurse of the missing dosage information.

On August 2, 2023, at 8:11 a.m. LPN-H stated when she set up the medications into the bubble packs she wrote the medication, dosage, directions for use, and prescription number. LPN-H stated she had missed putting the dosage on the medication card.

The licensee's 7.08 Medication Management - Administration & Setup policy revised May 1, 2022, identified assistance with medication and medication administration would be documented on the MAR by entering the ULP initials under the date and opposite the medication and dose given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ____ B. WING ____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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
01760	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	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 interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 31, 2023, at 11:45 a.m. registered nurse/owner (RN/O)-C and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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
01770	Continued From page 47	01770		

R4's Service Plan dated July 17, 2023, and signed by R4, indicated R4 received medication administration. R4's service plan did not include medication setup.

R4's prescriber orders dated May 24, 2023, included three for blood pressure, two for chronic obstructive pulmonary disease (disease that causes obstructed airflow from the lungs), one diuretic, two for memory, one for acid reflux, three for prostate enlargement, one blood thinner, and one supplement.

On August 2, 2023, at 8:11 a.m. licensed practical nurse (LPN)-H stated she completed a medication set up for R4 because his medications came in bottles from the veterans administration (VA). LPN-H stated she placed the medication set up in a bubble card and sealed the foil on the back of the card for individual doses and wrote the medication name, dosage, directions, and prescription number on the label. LPN-H stated she did not document the medication set up anywhere in R4's record or for anyone else getting a medication set up.

R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration.

On August 2, 2023, at 8:25 a.m. registered nurse/owner (RN/O)-C stated she was not aware the medication set up was not being documented in the resident's record.

The licensee's 7.08 Medication Management - Administration & Setup dated revised May 1, 2022, identified a licensed nurse would correctly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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
01770	Continued From page 48 and accurately document any medication setup provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a 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	02040		

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	33311	A. BUILDING: ______ B. WING ______	08/03/2023

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02040	Continued From page 49 or has the potential to affect a large portion or all of the residents). Findings include: On August 1, 2023, at approximately 3:00 p.m., survey staff requested a safety risk or hazard vulnerability assessment of the physical environment from the registered nurse/owner (RN/O)-C. Records were reviewed by survey staff on August 1, 2023, between 3:00 p.m. and 4:00 p.m. Record review of the available documentation indicated that the licensee had not included a safety risk assessment or hazard vulnerability assessment of the physical environment that identified safety risks or hazards on and around the property with mitigation factors. On August 1, 2023, at approximately 4:00 p.m., the RN/O-C verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

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LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

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02110	Continued From page 50 design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 51	02110		

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 included:

The licensee had an assisted living with dementia care license effective August 1, 2022.

R3 and R4's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include:
- philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;
- evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed;
- wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
- staff training specific to dementia care;
- description of life enrichment programs and how activities were implemented;
- description of family support programs and efforts to keep the family engaged;
- limiting the use of public address and intercom systems for emergencies and evacuation drills only;
- transportation coordination and assistance to and from outside medical appointments; and
- safekeeping of residents' possessions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 52 On August 3, 2023, at 10:26 a.m. registered nurse/owner (RN/O)-C stated none of the current residents had received the required policies. RN/O-C further stated she was not aware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R4) with a bedrail. This resulted in an immediate order for correction on August 1, 2023, at 1:15 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ______ B. WING ______	08/03/2023

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LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

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02310	Continued From page 53 situation has occurred only occasionally). The findings include: On August 1, 2023, at 10:40 a.m., the surveyor observed a bed rail on the left upper side of R4's bed. The device was a single, metal, homemade, upside down "L" shaped device, wrapped in gray duct tape. The device was bolted to the bedframe. R4 stated he used the assistive device to get in and out of bed. R4 further indicated his son-in-law had engineered the device. R4's diagnoses included diabetes, atrial fibrillation (abnormal heart rhythm), and congestive heart failure (heart muscle doesn't pump blood as well as it should). R4's Service Plan dated July 17, 2023, indicated R4 received services including medication management, assistance with compression stockings, international normalized ratio (INR) checks (how long it takes blood to clot), blood sugar checks, laundry, and light housekeeping. R4's Clinical Update Assessment dated July 20, 2023, identified R4 was independent with bed mobility, transfers, and ambulation. The assessment further identified R4 had an electric bed without any assistive devices. R4's record lacked a bed rail assessment and proof of receiving education on the risks and benefits of bed rail use. On August 1, 2023, at 12:15 p.m. clinical nurse supervisor (CNS)-B stated there was no risk vs benefit or assessment of R4's bedrail because it had never been identified as a bed mobility	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: ____ B. WING ____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 54 device. CNS-B stated she had only observed R4's continuous positive airway pressure (CPAP) (machine that uses air pressure to keep a person's airways open while they sleep) tubing hanging from the bed rail. CNS-B further stated she had never asked R4 if he used it for bed mobility. On August 1, 2023, registered nurse/owner (RN/O)-C stated R4's family engineered the bed rail to hold R4's CPAP tubing at least six months ago. RN/O-C stated she was not aware R4 was utilizing the bed rail for mobility and no assessments had been completed. The licensee's 6.28 Side Rails policy dated May 1, 2022, noted when side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On August 2, 2023, at 8:25 a.m. the immediacy of correction order 2310 was removed as confirmed by email correspondence with evaluation supervisor; however, non-compliance remains at a scope and level of G.	02310		

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

Type: Full
Date: *08/02/23*
Time: 10:03:11
Report: 1009231125

Food and Beverage Establishment Inspection Report

Location:
Lewiston Senior Living - Upstairs Dining Room Serving Kitchen
505 East Main Street
Lewiston, MN55952
Winona County, 85

Establishment Info:
ID #: 0037831
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075223500
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.

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

THERE ARE TWO RECTANGULAR HOLES THAT HAVE BEEN CUT INTO THE WALL BY THE UPRIGHT COOLER/FREEZER (POSSIBLY TO ACCESS PLUMBING FOR REPAIR). REPAIR THESE HOLES TO BE SMOOTH, DURABLE, AND EASILY CLEANABLE.

Comply By: 09/02/23

Surface and Equipment Sanitizers

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

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

Quaternary Ammonia: = at Degrees Fahrenheit
Location: Three-compartment sink-not mixed
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Turbo Air, milk
Violation Issued: No

Type: Full
Date: *08/02/23*
Time: 10:03:11
Report: 1009231125

Food and Beverage Establishment Inspection Report

Lewiston Senior Living - Upstairs Dining Room Serving Kitchen

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

Discussion:

Meals are prepared in the kitchen downstairs. Service is currently for about 21 people. The food is brought up approximately 10 minutes prior to service time, and placed in the preheated steam table for immediately plating and service. Everything is taken back to the downstairs kitchen for cleaning and sanitizing.

There is a refrigerator/freezer unit in this room with milk, juice, frozen treats, and a few other items. Toast may occasionally be made in this room as well in the two toasters.

A three compartment sink is also in this kitchenette for the occasional warewashing if needed.

The handwashing sink has the required supplies.

The kitchenette was found to be clean and tidy today.

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 1009231125 of 08/02/23.

Certified Food Protection Manager: Brenda Faber

Certification Number: ______________ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: ______________________

Brenda Faber
Culinary Manager

Signed: Lesli Haines

Lesli Haines, RS/REHS
Public Health Sanitarian III
Rochester District Office
507-206-2745
lesli.haines@state.mn.us

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

DEPARTMENT OF HEALTH

Type: Full
Date: *08/02/23*
Time: 10:02:38
Report: 1009231124

Food and Beverage Establishment Inspection Report

Location:
Lewiston Senior Living
505 East Main Street
Lewiston, MN55952
Winona County, 85

Establishment Info:
ID #: 0037831
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075223500
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

THE CHLORINE CONCENTRATION IN THE DISHMACHINE MEASURED FAR LESS THAN 50ppm. THE LOG IS INCONSISTENT WITH THE ACTUAL MEASUREMENT. HAVE THE UNIT SERVICED, RETRAIN STAFF ON ACCURATELY MEASURING AND RECORDING, AND ENSURE THE CONCENTRATION IS 50-100ppm ALWAYS

Comply By: 08/02/23

6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

THERE IS A SIGNIFICANT GAP ALONG THE BOTTOM OF THE DOOR AT THE LANDING OF THE STAIRWAY LEADING UPSTAIRS FROM THE KITCHEN THROUGH WHICH DAYLIGHT CAN BE SEEN. THIS MAY ALLOW PEST ENTRANCE. INSTALL A DOOR SWEEP.

Comply By: 09/02/23

Surface and Equipment Sanitizers

Chlorine: < 50 ppm at Degrees Fahrenheit
Location: Dishmachine
Violation Issued: Yes

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

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: Kolpak, milk
Violation Issued: No

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

DISCUSSION:

Brenda Faber is the new Culinary Manager, and has been in this roll for about a month. She has past experience in foods service, and has a current MDH Certified Food Protection Manager certificate. Brende exhibits very good food safety knowledge, and keeps very well organized food safety records and logs.

Please be aware that Norovirus, often thought to be the "stomach flu" continues to be the leading cause of foodborne illness outbreaks. A person who has contracted Norovirus continues to be contagious at least three days after symptoms have subsided. Because of this, it is important to report and record any illnesses, even if staff did not report to work while ill.

To further reduce the risk of transmitting Norovirus and other pathogens that may cause illness, continue to closely monitor handwashing, proper cleaning and sanitizing of equipment and surfaces, do not allow bare-hand contact with ready-to-eat foods.

Illnesses are reported and recorded. No illnesses have been reported recently.

Foods come from approved sources. They are checked at receiving for condition and temperatures.

Cooler and freezer temperatures are monitored and logged, as are food cook temperatures and sanitizer concentrations. I recommend measuring a food product temperature in the coolers with your calibrated food thermometer as it is difficult to know when an ambient air thermometer looses accuracy.

There are few leftovers, and they are discarded at the end of service. No cooling and reheating for reservice takes place currently. When cold weather returns, soups will be on the menu, and may go through the cooling process. Brenda has an ice paddle to assist with rapidly cooling soups. We also discussed using a deep ice bath in the food prep sink in conjunction with the ice paddle to increase the speed of cooling even more. We discussed other methods of cooling as well.

Thawing is done in the walk-in cooler. No vacuum packaged fish is currently used in this facility. If vacuum packaged fish is used in the future, please be sure to open the package during thawing to introduce oxygen in order to prevent the possibility of the growth of Clostridium botulinum.

I observed excellent date marking practices today.

Foods are properly stored so as to prevent cross-contamination between raw animal foods and ready to eat

Food and Beverage Establishment Inspection Report

foods.

Shell eggs are not pasteurized. It is important to carefully measure the cook temperature on all eggs prepared for this vulnerable population to ensure any possible Salmonella bacteria is killed. Using pasteurized shell eggs is recommended. Eggs that are pasteurized will be stamped with the letter "P" on the shell.

Chemicals are stored separate and away from foods and equipment

Plunkett's services the facility for pest management. No signs of pests were seen today.

The facility was found to be very clean and well maintained.

Report emailed to: b.faber@lewistonseniorliving.com

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 1009231124 of 08/02/23.

Certified Food Protection Manager: Brenda K. Faber

Certification Number: FM112926 Expires: 09/21/25

Inspection report reviewed with person in charge and emailed.

Signed: ______________________

Brenda K. Faber
Culinary Manager

Signed: Lesli Haines

Lesli Haines, RS/REHS
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