Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 27, 2024

Licensee
Heathers Manor
3000 North Douglas Drive
Crystal, MN 55422

RE: Project Number(s) SL21623015

Dear Licensee:

On October 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders were corrected from the March 1, 2024, survey and follow-up surveys completed on May 21, 2024 and August 01, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 30, 2024

Licensee
Heathers Manor
3000 North Douglas Drive
Crystal, MN 55422

RE: Project Number(s) SL21623015

Dear Licensee:

On August 1, 2024, 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 March 1, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 1, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 1, 2024, found not corrected at the time of the August 1, 2024, follow-up survey and/or subject to penalty assessment are as follows:

2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on August 1, 2024 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced 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.

IMPOSITION OF FINES:

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

§144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

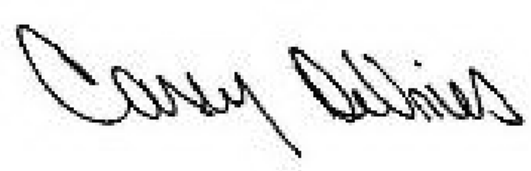
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	21623	A. BUILDING: _____ B. WING _____	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

(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: SL21623015-2 On August 1, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 1, 2024. At the time of the survey, there were 54 residents, all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	{0 250}		

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{0 250}	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, 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;	{0 250}		

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{0 250}	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action is 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 is 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	{0 510}		

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{0 510}	Continued From page 3 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: No further action is required.	{0 510}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action is required.	{0 630}		
{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 is required.	{0 650}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	{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 is 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 This MN Requirement is not met as evidenced by: No further action is required.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

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{0 730}	Continued From page 7 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action is required.	{0 730}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	{0 780}		

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{0 780}	Continued From page 8 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: No further action is required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action is required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	{0 800}		

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{0 800}	Continued From page 9 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: No further action is required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	{0 810}		

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{0 810}	Continued From page 10 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action is required.	{0 910}		
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	{01060}		

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{01060}	Continued From page 11 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		

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{01060}	Continued From page 12 No further action is required.	{01060}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	{01370}		

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{01370}	Continued From page 13 (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 is 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: (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 is required.	{01380}		
{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;	{01470}		

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{01470}	Continued From page 14 (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 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	{01470}		

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{01470}	Continued From page 15 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 is required.	{01470}		
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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	{01530}		

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{01530}	Continued From page 16 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 is required.	{01530}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}		

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{01620}	Continued From page 17 This MN Requirement is not met as evidenced by: No further action is 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. This MN Requirement is not met as evidenced by: No further action is required.	{01640}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	{01730}		

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{01730}	Continued From page 18 management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	{01730}		

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{01730}	Continued From page 19 This MN Requirement is not met as evidenced by: No further action is required.	{01730}		
{01760} SS=E	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 is required.	{01760}		
{01830} SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: No further action is required.	{01830}		

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{01880}	Continued From page 20	{01880}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action is required.	{01880}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action is required.	{01890}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:	{01940}		

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{01940}	Continued From page 21 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action is required.	{01940}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	{01960}		

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{01960}	Continued From page 22 This MN Requirement is not met as evidenced by: No further action is required.	{01960}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action is required.	{01970}		
{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 provide care and services according to acceptable health care, medical or nursing standards for one of two residents (R9) with a transfer pole assistive device.	{02310}		

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{02310}	Continued From page 23 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 situation has occurred only occasionally). The findings include: R9 admitted on August 16, 2012, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021. R9's diagnoses included dementia, hypertension (HTN), respiratory failure, acute on chronic diastolic heart failure, depression, and anxiety. R9's service plan signed March 14, 2024, indicated R9 received assistance with bathing, medication administration, escorts, dressing, ileostomy bag changes, mobility, toileting, and grooming. In addition, the service plan read, "I am using a transfer pole to assist with successful transfers. Transfer poles do pose a risk of entrapment if improperly used. Staff should ensure transfer pole is positioned greater than 12 inches from the bed, toilet, or chair or less than 2 2/3 inches to minimize risks. Staff should ensure transfer pole is not leaning and is securely framed between ceiling and floor. Staff should notify Licensed Nurse of concerns with the device/function. LN will review quarterly." R9's record contained document titled Managed Risk Agreement dated May 20, 2024, and another document titled Device Evaluation with an	{02310}		

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{02310}	Continued From page 24 effective date of March 20, 2024. R9's Managed Risk Agreement under section three titled Possible/Probable Consequences of Resident (family) Desire had the word "none" documented followed by a handwritten sentence in blue ink. Section four titled Alternatives to Minimize Risk, had "none" documented. The handwritten note in blue ink was illegible. R9's Device Evaluation and Managed Risk Agreement mentioned above lacked review of whether the device was appropriately placed per manufacturer guidelines, acknowledgement of safety risks involved with any specific resident request for placement, lacked offer of alternative options, and lacked interventions in place to mitigate the known safety risks. In addition, R9's Device Evaluation was required to be completed every 90 days. The previous Device Evaluation was dated May 20, 2024. The next Device Evaluation was required to be completed by June 18, 2024. There was no other documentation provided by [licensee] pertaining to R9's transfer pole. On August 1, 2024, at 11:36 a.m., executive director (ED)-T stated they were unable to read the handwritten sentence in blue ink on R9's Managed Risk Agreement. On August 1, 2024, at 11:57 a.m., clinical nurse supervisor (CNS)-W stated there was no other documentation pertaining to the transfer pole for R9. On August 1, 2024, at 12:10 p.m., ED-T stated the licensee's nurse completed the Device Evaluation assessment that included providing	{02310}		

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{02310}	Continued From page 25 education to the resident and family about the risks using the transfer pole. On August 1, 2024, at 12:12 p.m., the surveyor inquired to CNS-W why the Device Evaluation lacked the required documentation. CNS-W stated they did not complete the assessment. On August 1, 2024, at 12:13 p.m., Regional Director of Clinical Services (RDOC)-S stated they were unsure why there was a handwritten note made on the Managed Risk Agreement and was unsure why R9's medical record lacked the required documentation. RDOC-S stated [licensee] had not received the correction orders from Minnesota Department of Health (MHD) from the previous survey completed May 21, 2024. On August 1, 2024, at 12:18 p.m., ED-T stated they were unsure why R9's medical record lacked the required documentation. ED-T stated the licensee had not received the correction orders from MHD survey completed May 21, 2024. On August 1, 2024, 12:34 p.m., the surveyor observed a white transfer pole extending from the floor to the ceiling, on the right side of R9's bed, located approximately one-and one-half foot from the head of the bed. The distance between the bed and transfer pole was approximately one-half inch ("). On August 1, 2024, at 12:57 p.m., RDOCS-S stated they were aware the Device Evaluation should be completed every 90 days and was not able to provide a reason for the Device Evaluation not being completed. On August 1, 2024, at 12:58 p.m., CNS-W stated	{02310}		

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	21623	A. BUILDING: _____ B. WING _____	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{02310}	Continued From page 26 they were aware Device Evaluation should be completed every 90 days and was unsure why it had not been completed. On August 2, 2024, at 8:00 a.m., the surveyor reviewed the email sent from MDH Enforcement to [licensee] with the subject, "[licensee] Evaluation Results - SL21623015". The email contained an Enforcement letter that indicated survey results, including penalties and correction order times frames. MDH staff received confirmation from Microsoft Outlook (email program) that ED-T had received and opened the email. The undated manufacturer's instructions for R9's security pole product number 1150, indicated the transfer pole had a warning of entrapment and fall hazard. The manufacturer's instructions read, "Do NOT use or place near any type of bed. Use of product on any bed may result in risk of entrapment. Stander Inc. recommends NOT installing product closer than the user's ability to safely walk around the pole or there may be a possibility of becoming entrapped between the pole and the side of any object adjacent to the pole. Small gaps between pole/swivel hand and other stationary objects can entrap and kill." In addition, people with Alzheimer's disease, dementia, sedated, confused, or frail were at increased risk of entrapment and falls. The 4.19 Assistive Devices policy dated March 1, 2024, indicated when assistive devices were in use the registered nurse (RN) shall conduct an assessment to identify the intended purpose of the assistive devices and the risks regarding the use of the assistive device. "Staff shall determine if the assistive device is considered to be safe. "Safe" shall be defined as meeting all of the	{02310}		

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{02310}	Continued From page 27 requirements listed below: a. The assistive devices are used consistent with manufacturer's directions. Be aware of assistive devices that slide between the mattress and box spring designed for toddler use. b. Nurse will get a doctor's order for the use of the assistive devices c. Nurse will conduct a quarterly safety function of the assistive devices or any other mechanical device and review the risk and benefit of the mechanical device. d. Staff will be train on hire, annually, and as needed on the function of the assistive devices or mechanical device. e. The assistive devices are installed securely and maintained in good operating condition. Be aware of "wobbly" assistive devices. f. The assistive devices design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means assistive devices zones 1,2, 3,and 4 must not exceed 4.7." No further information was provided.	{02310}		

Electronically Delivered
June 4, 2024

Licensee
Heathers Manor
3000 North Douglas Drive
Crystal, MN 55422

RE: Project Number(s) SL21623015

Dear Licensee:

On May 21, 2024, 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 March 1, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 1, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 1, 2024, found not corrected at the time of the May 21, 2024, follow-up survey and/or subject to penalty assessment are as follows:

2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on May 21, 2024 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced 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.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you 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 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.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

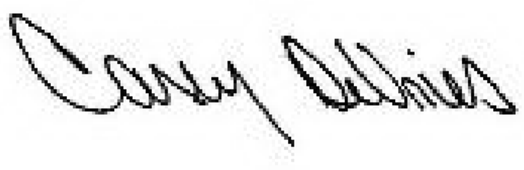
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
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{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: SL21623015-1 On May 20, 2024, through May 21, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 1, 2024. At the time of the survey, there were 54 residents, all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	{0 250}		

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{0 250}	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, 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;	{0 250}		

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{0 250}	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action is 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 is 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	{0 510}		

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{0 510}	Continued From page 3 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: No further action is required.	{0 510}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action is required.	{0 630}		
{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 is required.	{0 650}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	{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 is 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 This MN Requirement is not met as evidenced by: No further action is required.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

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{0 730}	Continued From page 7 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action is required.	{0 730}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	{0 780}		

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{0 780}	Continued From page 8 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: No further action is required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action is required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	{0 800}		

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{0 800}	Continued From page 9 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: No further action is required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	{0 810}		

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{0 810}	Continued From page 10 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: No further action is required.	{0 910}		
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	{01060}		

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{01060}	Continued From page 11 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		

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{01060}	Continued From page 12 No further action is required.	{01060}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	{01370}		

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{01370}	Continued From page 13 (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 is 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: (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 is required.	{01380}		
{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;	{01470}		

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{01470}	Continued From page 14 (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 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	{01470}		

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{01470}	Continued From page 15 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 is required.	{01470}		
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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	{01530}		

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{01530}	Continued From page 16 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 is required.	{01530}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}		

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{01620}	Continued From page 17 This MN Requirement is not met as evidenced by: No further action is 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. This MN Requirement is not met as evidenced by: No further action is required.	{01640}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	{01730}		

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{01730}	Continued From page 18 management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	{01730}		

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{01730}	Continued From page 19 This MN Requirement is not met as evidenced by: No further action is required.	{01730}		
{01760} SS=E	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 is required.	{01760}		
{01830} SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: No further action is required.	{01830}		

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{01880}	Continued From page 20	{01880}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action is required.	{01880}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action is required.	{01890}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:	{01940}		

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{01940}	Continued From page 21 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action is required.	{01940}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	{01960}		

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{01960}	Continued From page 22 This MN Requirement is not met as evidenced by: No further action is required.	{01960}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action is required.	{01970}		
{02310} SS=I	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 provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R9, R11) with transfer pole assistive devices.	{02310}		

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{02310}	Continued From page 23 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R9 R9 admitted on August 16, 2012, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021. R9's diagnoses included dementia, hypertension (HTN), respiratory failure, acute on chronic diastolic heart failure, depression, and anxiety. R9's service plan signed March 14, 2024, indicated R9 received assistance with bathing, medication administration, escorts, dressing, ileostomy bag changes, mobility, toileting, and grooming. In addition, the service plan read, "I am using a transfer pole to assist with successful transfers. Transfer poles do pose a risk of entrapment if improperly used. Staff should ensure transfer pole is positioned greater than 12 inches from the bed, toilet, or chair or less than 2 2/3 inches to minimize risks. Staff should ensure transfer pole is not leaning and is securely framed between ceiling and floor. Staff should notify Licensed Nurse of concerns with the device/function. LN will review quarterly." On May 21, 2024, at 9:41 a.m., the surveyor observed a transfer pole extending from the floor	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21623	A. BUILDING: _____ B. WING _____	R 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

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{02310}	Continued From page 24 to the ceiling, on the right side of R9's bed, located approximately one and a half feet from the head of the bed, touching R9's mattress. R9's Device Evaluation-V3 dated March 20, 2024, indicated R9 used a transfer pole and the device affected R9's mobility and transfer status in a positive manner to promote R9's independence. The device's benefits for R9 included the following: contributes to self-performance, enhanced bed mobility, enhanced transfers, increased sense of safety and security, and potentially protects from injury. The potential risks section included two sections. The first section was titled "Potential Risks" and indicated the following could be risks of the device for R9: falls, loss of dignity, and "other". The second section was titled "Explain" and read, "Do NOT use or place near any type of bed. Use of product on any bed may result in risk of entrapment. Recommends NOT installing product closer ability to safely walk around the pole." R9's Managed Risk Agreement was completed during the survey on May 20, 2024. The assessment indicated the possible cause of concern was a transfer pole, an assessment was completed and there were no concerns noted, there were no consequences of resident's desire, and R9 wanted to continue to use a transfer pole. R9's Minnesota AL comprehensive/Quarterly/14 day /Assessment-V3 nursing assessment dated May 17, 2024, did not address the transfer pole. R9's Device Evaluation, Managed Risk Agreement, and Nursing Assessments mentioned above all lacked review of whether the device was appropriately placed per manufacturer guidelines, acknowledgement of safety risks	{02310}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{02310}	Continued From page 25 involved with any specific resident request for placement, lacked offer of alternative options, and lacked interventions in place to mitigate the known safety risks. The undated manufacturer's instructions for R9's security pole product number 1150, indicated the transfer pole had a warning of entrapment and fall hazard. The manufacturer's instructions read, "Do NOT use or place near any type of bed. Use of product on any bed may result in risk of entrapment. Stander Inc. recommends NOT installing product closer than the user's ability to safely walk around the pole or there may be a possibility of becoming entrapped between the pole and the side of any object adjacent to the pole. Small gaps between pole/swivel hand and other stationary objects can entrap and kill." In addition, people with Alzheimer's disease, dementia, sedated, confused, or frail were at increased risk of entrapment and falls. R11 R11 admitted to the licensee on June 14, 2021, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021. R11's diagnoses included HTN, aphasia, diabetes type two, dementia, delirium, depression, anxiety, insomnia, and heart failure. R11's service plan signed April 3, 2024, indicated R11 received assistance with bathing, dressing, laundry, toileting, shaving, and medication administration. In addition, the service plan read, "I am using a transfer pole to assist with successful transfers. Transfer poles do pose a risk of entrapment if improperly used. Staff should ensure transfer pole is positioned greater than 12	{02310}		

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{02310}	Continued From page 26 inches from the bed, toilet, or chair or less than 2 2/3 inches to minimize risks. Staff should ensure transfer pole is not leaning and is securely framed between ceiling and floor. Staff should notify Licensed Nurse of concerns with the device/function. LN will review quarterly." On May 21, 2024, at 9:39 a.m., the surveyor observed a transfer pole extending from the floor to the ceiling located approximately less than six inches from the top left corner of R11's bedframe. R11's Device Evaluation dated November 7, 2022, indicated a transfer pole was tried or offered to the R11 to enhance transfer status however, the evaluation did not indicate the transfer pole was implemented. The device evaluation form was not completed again until May 20, 2024, during the survey. R11's Managed Risk Agreement signed by R11 on December 10, 2022, indicated the possible cause of concern was a transfer pole, an assessment was completed and there were no concerns, there were no consequences of resident's desire, and R11 wanted to continue to use a transfer pole to assist with mobility. R11's Minnesota AL Comprehensive /Quarterly/14 Day Assessment -V3 dated March 12, 2024, did not address the transfer pole. R11's Device Evaluation, Managed Risk Agreement, and Nursing Assessments mentioned above all lacked review of whether the device was appropriately placed per manufacturer guidelines, acknowledgement of safety risks involved with any specific resident request for placement, lacked offer of alternative options, and lacked interventions in place to mitigate the	{02310}		

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{02310}	Continued From page 27 known safety risks. The undated manufacturer'ss instructions for R11's security pole and curve grab bar product number 1100 indicated the transfer pole had a warning of entrapment and fall hazard. The manufacturer's instructions read, "Do NOT use or place near any type of bed. Use of product on any bed may result in risk of entrapment. Stander Inc. recommends NOT installing product closer than the user's ability to safely walk around the pole or there may be a possibility of becoming entrapped between the pole and the side of any object adjacent to the pole. Small gaps between pole/swivel hand and other stationary objects can entrap and kill." In addition, people with Alzheimer's disease, dementia, sedated, confused, or frail were at increased risk of entrapment and falls. On May 20, 202, at 2:32 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated R11's assessment was an "old" device assessment that was completed prior to the initial survey. CNS/LALD-D stated after the initial survey the licensee updated the device evaluation assessment and had been implementing the new device evaluation assessment with each quarterly review for their residents at large. The surveyor inquired if all residents with devices have had a new device evaluation. CNS/LALD-D stated everyone who utilized a bed rail had received a new device evaluation assessment however, residents with transfer poles were receiving a new device assessment upon their quarterly review. On May 21, 2024, at 10:10 a.m., CNS/LALD-D stated bed poles were assessed immediately when initiated, on a continuous basis, and as	{02310}		

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{02310}	Continued From page 28 needed. The surveyor inquired what continuously meant. Regional director of clinical services (RDOCS)-S stated quarterly to ensure the device were still appropriate. The surveyor inquired if they were completing assistive device assessments quarterly why the surveyor was provided an assessment from 2022 for R11. RDOCS-S stated they noticed yesterday that an assessment had not been completed since 2022 for R11 and they completed a new device evaluation on May 20, 2024. RDOCS-S stated the licensee created a plan of correction for assistive devices in the facility however, they received the orders late because the email that contained the orders went to an employee who was no longer employed for the licensee and the licensee had not completed all of the corrections needed for assistive devices. On May 21, 2024, at 11:08 a.m., CNS/LALD-D stated nursing looked at the manufacture's guidelines to ensure there were no recalls and to properly install transfer poles. CNS/LALD-D stated once a transfer pole was installed, they would ensure the transfer pole was installed per manufactures guidelines, was sturdy, and residents had the ability to safely use the device. RDOCS-S stated they noticed the new assessment did not include a section related to the device being installed properly and the current assessment allowed a small number of characters for the nurses to write in the information. RDOCS-S stated they contacted a coworker at their corporate office yesterday to update the device evaluation form. The surveyor showed CNS/LALD-D and RDOCS-S a picture of R9 and R11's transfer poles and inquired if they were installed per manufacturer's installation guidelines. CNS/LALD-D and RDOCS both stated R9 and R11's transfer poles were located too	{02310}		

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{02310}	Continued From page 29 close to the bed. CNS/LALD-D stated they did not know who placed the transfer pole nor did they know how the transfer poles were so close to the beds. RDOCS-S stated they were unable to get a hold of the previous director of nursing (DON) to see who or when the transfer poles were placed. CNS/LALD-D stated R9's risk and benefit were not completed until May 20, 2024, because they were transitioning to a different position at a different sister facility and forgot to have R9 sign the form. RDOCS-S stated the monitoring listed in the service plan was not being documenting on by the unlicensed personnel. The 4.19 Assistive Devices policy dated March 1, 2024, indicated when assistive devices were in use the registered nurse (RN) shall conduct an assessment to identify the intended purpose of the assistive devices and the risks regarding the use of the assistive device. "Staff shall determine if the assistive device is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The assistive devices are used consistent with manufacturer's directions. Be aware of assistive devices that slide between the mattress and box spring designed for toddler use. b. Nurse will get a doctor's order for the use of the assistive devices c. Nurse will conduct a quarterly safety function of the assistive devices or any other mechanical device and review the risk and benefit of the mechanical device. d. Staff will be train on hire, annually, and as needed on the function of the assistive devices or mechanical device. e. The assistive devices are installed securely and maintained in good operating condition. Be aware of "wobbly" assistive devices. f. The assistive devices design is consistent with	{02310}		

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{02310}	Continued From page 30 the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means assistive devices zones 1,2, 3,and 4 must not exceed 4.7." No further information was provided.	{02310}		

Electronically Delivered

April 2, 2024

Licensee
Heathers Manor
3000 North Douglas Drive
Crystal, MN 55422

RE: Project Number(s) SL21623015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. 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), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

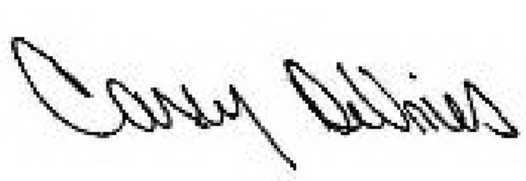
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
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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: SL21623015-0 On February 26, 2024, through March 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 56 residents: 37 residents receiving services under the Assisted Living license. Immediate correction orders were identified on February 27, 2024, issued for SL21623015-0, tag identification 1290 and 2310. On February 28, 2024, the immediacy of correction orders 1290 and 2310 were removed, however, non-compliance remained, and the scope and levels remained unchanged.	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	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, 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;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 February 26,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

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0 250	Continued From page 3 2024, at 9:38 a.m., licensed assisted living director (LALD)-C 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	0 250		

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0 250	Continued From page 4 use information provided in this application, which 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.	0 250		

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0 250	Continued From page 5 - I have examined this application and all 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 six was electronically signed by LALD-C on March 31, 2023. The licensee had an assisted living license issued on July 1, 2023, with an expiration date of June 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - infection control practices; - reminders for medications, treatments, or exercises, if provided;	0 250		

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0 250	Continued From page 6 - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On February 28, 2024, at 2:41p.m., LALD-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0480, 0510, 0630, 0650, 0660, 0680, 0730, 0780, 0790, 0800, 0810, 0910, 1060, 1290, 1370, 1380, 1470, 1530, 1620, 1640, 1730, 1760, 1830, 1880, 1890, 1940, 1960, 1970, 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	0 480		

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0 480	Continued From page 7 by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	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	0 510		

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0 510	Continued From page 8 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene, gloves, medication administration, and sharps disposal. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: GLOVES AND HAND HYGIENE On February 27, 2024, from 7:16 a.m. to 7:48 a.m., the surveyor observed licensed practical nurse (LPN)-E provide activities of daily living (ADLs) to R9. The surveyor observed LPN-E apply gloves, gather clothing, cue R9 to walk to the bathroom, cue R9 to sit on the toilet, remove R9's night gown, wash and dry R9's underarms, back, chest, and face, apply deodorant to R9's underarms, apply lotion to the upper extremities of R9, dress R9's upper body, cue R9 to stand, remove R9's incontinent pull up, and complete perineal care on R9. Without change of gloves or performing hand hygiene, LPN-E placed a new	0 510		

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0 510	Continued From page 9 incontinent pull up and pants on R9's legs, cued R9 to stand, raised the pull up and pants, and applied a sweater to R9. LPN-E cued R9 to complete oral care, cleaned items used during morning cares, and removed gloves. Without performing hand hygiene, LPN-E brushed R9's hair, and performed hand hygiene. On February 27, 2024, at 7:49 a.m., the surveyor observed LPN-E apply gloves, complete blood glucose monitoring on R9, and remove gloves and place them in their hand. Without performing hand hygiene, LPN-E removed a sharps container from R9's room, walked container to the trash room and discarded sharps container and gloves, walked to common area lounge, and performed hand hygiene. On February 27, 2024, at 8:01 a.m., the surveyor observed LPN-E apply gloves, raise R10's bed, detach R10's brief, clean R10's abdominal folds and groin, turn R10 to the side, remove R10's soiled brief, and complete perineal care on R10. Without removing gloves or performing hand hygiene, LPN-E cleaned R10 buttock and removed gloves. Without performing hand hygiene, LPN-E applied a new pair of gloves placed a clean disposable pad and incontinent brief under R10, applied barrier cream to R10's buttock, and removed one glove. Without performing hand hygiene LPN-E applied one new glove, turned R10 onto their back, provided perineal care, applied barrier cream to the abdominal folds and groin, and removed one glove. Without performing hand hygiene, LPN-E applied a one new glove, attached R10's brief, covered R10, removed the garbage bag, placed a new garbage bag to the garbage can, and removed gloves. Without performing hand hygiene, LPN-E exited R10's room, discarded	0 510		

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0 510	Continued From page 10 trash down the hallway in the garbage room, walked to a common room, and performed hand hygiene. On February 27, 2024, LPN-E stated they complete training on infection control yearly through EduCare (a training software). LPN-E stated they were trained to perform hand hygiene before and after care, after perineal care, and with glove changes. The surveyor inquired why they did not perform hand hygiene with glove changes or after perineal cares. LPN-E stated the facility did not provide soap or paper towels in the resident's rooms and families would become upset if you used the resident's personal supplies. On February 28, 2023, at 1:25 p.m., director of clinical services (DOCS)-S stated staff were trained on infection control upon hire, annually, and as needed. Clinical nurse supervisor (CNS)-D stated hand washing should occur with medication passes, when providing cares, and before and after glove use. DOCS-S stated they encouraged the communities to purchase soap, sanitizer, and towels to place in totes so hand hygiene could be completed in resident rooms. DOCS-S stated staff were not allowed to use resident soap or paper towels. CNS-D stated they did not know if this was occurring because this was their first week employed with the licensee. The licensee's 6.05 Gloves policy dated January 1, 2017, indicated after glove removal employees would rewash hands. The licensee's 6.06 Hand Washing policy dated January 1, 2017, indicated hand washing shall be completed: - before, during, and after preparing food or before eating food; - before and after caring for someone who is sick;	0 510		

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0 510	Continued From page 11 - before and after treating a cut or wound; - after using the toilet; - after changing diapers or cleaning up after someone who has used the toilet; - after blowing your nose, coughing, or sneezing; - after touching an animal or animal waste; - after handling pet food or pet treats; and - after touching garbage. The CDC document titled Hand Hygiene Guidance dated January 30, 2020, recommended health care personnel use an alcohol-based hand rub or wash hands with soap and water for the following clinical indications: - immediately before touching a patient; - before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or the patient's immediate environment; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. MEDICATION On February 27, 2024, at 9:02 a.m., the surveyor observed LPN-A punch medication out of blister packs into their ungloved hand and then place the following medication into the medication cup: amlodipine besylate 10 milligrams (mg), multivitamin tablet, Citrucel 500 mg, apixaban 5 mg, lisinopril 40 mg finasteride 5mg, and Zoloft 50 mg. In addition, LPN-E dropped furosemide 20 mg into the medication cart, picked the medication up with their ungloved hands, and placed it into the medication cup. At 9:11 a.m., the surveyor observed LPN-A administer the medication listed above to R11.	0 510		

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0 510	Continued From page 12 On February 27, 2024, at 9:18 a.m., LPN-A stated dropped medication should be disposed of. The surveyor inquired why they did not dispose the medication furosemide. LPN-A stated the medications were delivered on a schedule and if they would have taken a new one, they would have run out of medication before the next delivery or they would have had to reorder the medication from pharmacy. In addition, LPN-A stated medications should not be touched with hands unless gloved and they did not know they touched the medications listed above. Licensee's document titled Procedures for Medication Administration dated November 2014, recommended when removing medication from a blister pack, hold the medication cup under the correct blister and punch the medication directly into the cup. SHARPS DISPOSAL On February 27, 2024, at 7:49 a.m., the surveyor observed a full sharps container on R9's floor. R9 stated the sharps container had been full for a couple of days. The surveyor observed LPN-E complete blood glucose monitoring on R9 then pry open R9's sharps container to discard used sharps. The surveyor inquired when sharps containers get discarded. LPN-E stated when they are full. The surveyor inquired if R9's sharps container was full. LPN-E stated it had "a little bit more" before it would be discarded. The surveyor inquired if the sharps container was filled past the full mark. LPN-E stated yes and removed the sharps container from R9's room. On February 28, 2024, at 1:28 p.m., DOCS-S stated staff were trained to discard sharps containers if they were three-fourths full.	0 510		

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0 510	Continued From page 13 The licensee's 6.04 Disposal of contaminated Materials dated January 1, 2017, indicated sharps containers should never be filled more than three-fourths full, then closed and disposed of per licensee's guidelines. The U.S. Food and Drug Administration (FDA) document titled Sharps Disposal Containers in Health Care Facilities dated April 29, 2021, recommended to close, and seal sharps containers when they are about three-fourths full and follow health care facility's policy and procedure for medical waste disposal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 630		

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0 630	Continued From page 14 licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of four residents (R2, 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: R2 R2 was admitted on April 2, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's record included a Residency Agreement signed by R2's legal representative on March 22, 2019. R2's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R3 R3 was an independent resident at the licensee's facility. R3's record included Assisted Living Contract	0 630		

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0 630	Continued From page 15 signed by R3 on August 6, 2021. R3's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R4 R4 admitted on June 23, 2021, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's record included Assisted Living Contract signed by R4 on June 6, 2021. R4's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On February 28, 2024, at 12:17 p.m. clinical nurse supervisor (CNS)-D stated, "I don't see that, maybe because they said there was no concern, at the end of the vulnerability they say resident does not seem to have any vulnerability requiring intervention at this time, but it would need to be checked off to indicate that, and I see that that wasn't checked so that is why they do not have that question answered." The licensee's Abuse and Neglect Prevention Plan dated December 1, 2023, indicated the nurse would complete a vulnerability assessment on admission and when there was a new vulnerability identified. The IAPP would be	0 630		

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0 630	Continued From page 16 implemented on the resident's service plan with approaches and interventions that would be monitored by the nurses and ULP. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 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 interview, and record review, the	0 650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

(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
0 650	Continued From page 17 licensee failed to ensure employee records contained the required content for one of three employees (unlicensed personnel (ULP)-P). 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-P ULP-P began employment with the licensee, under the licensee's former comprehensive license and started providing assisted living services June 8, 2023. ULP-P's employee record lacked the following documentation of required competency training completed by a registered nurse (RN): -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices: -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; -preparing medications and all medication route	0 650		

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0 650	Continued From page 18 procedures; -catheter or stoma care; -Broda chair; -mechanical lifts; -blood glucose; -oxygen; -compression stockings; -ace wraps; and -wound care. On February 28, 2024 at 9:19 a.m., ULP-P stated that she had been taught in all of the above listed items and stated, "I have worked here since June last year, [director of clinical services (DOCS)-S] came here and trained me in a med class and then I shadowed the aides for a few days and then I went with the nurse [registered nurse (RN)-N] and she watched me do the meds and cares for a day so she could sign me off to be on my own." On February 28, 2024, at 12:52 p.m., DOCS-S stated after ULP were trained on the required topics, the RN or licensed practical nurse (LPN) with the RN overseeing them, would complete a competency evaluation with the ULP. DOCS-S stated they reached out to the previous clinical nurse supervisor (CNS) to attempt to locate the documents. DOCS-S stated competencies were usually stored in a binder in the CNS office or in the employee record. The licensee's 3.05 Delegated Nursing Services policy, dated December 29, 2016, read, "A RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the client [resident]."	0 650		

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0 650	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three employees (licensed practical nurse (LPN)-E). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 20 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 facility TB risk assessment form dated March 15, 2023, indicated the facility was at a low risk for TB transmission. LPN-E was hired on January 15, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. LPN-E's employee record included a Baseline TB Screening Tool for Healthcare Workers (HCWs) signed by LPN-E on April 15, 2021. LPN-E's record lacked evidence that a baseline TB screening was completed. On February 28, 2024, at 1:04 p.m., director of clinical services (DOCS)-S stated the business office manager (BOM) completed a check list for each employee's TB record. DOCS-S stated the two-step Mantoux was completed on site unless there was a positive reaction on the first step. DOCS-S stated if the first Mantoux was positive they would send the employee to and occupational health clinic for a QuantiFERON gold or a chest x-ray. DOCS-S stated the BOM conducted an annual review of TB records and employee's TB records were kept in the employee file. On February 28, 2024, at 1:48 a.m. licensed	0 660		

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0 660	Continued From page 21 assisted living director (LALD)-C provided the surveyor a document that contained information requested by the surveyor. LALD-C indicated in writing they did not have evidence of a baseline TB completed for LPN-E. The licensee's Tuberculosis Screening of Employees policy dated March 11, 2021, read, "3. All employees at all communities must have a baseline TB screening perfom1ed by a licensed nurse consisting of three components: o Assessing for current symptoms o Assessing TB history and o Testing for TB with a two-step Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA)." The CDC's document titled TB Screening and Testing of Health Care Personnel dated May 16, 2019, indicated a baseline individual TB risk assessment should be completed upon. In addition, the document indicated a TST was used to test health care personnel for TB upon hire, and two-step testing should be used. 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	0 680		

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0 680	Continued From page 22 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 23 On February 26, 2024, at 11:35 a.m., licensed assisted living director (LALD)-C provided the licensee's EPP. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - risk assessment of interruption of services and consider emerging infectious diseases; - population needs: independence, communication, transportation, supervision and medical care; - identify staff specific roles in another's absence through succession planning and delegation of authority; - identify qualified person who is authorized in writing to act in the absence of the administrator; -process for emergency plan (EP) collaboration; - subsistence needs for staff and patients; - procedures for tracking staff and patients; - policies and procedures including evacuation; - policies and procedure for sheltering; - Policies and procedures for medication documentation; - policies and procedures for volunteers; - roles under a waiver declared by secretary; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - long-term care (LTC) family notifications; - emergency prep training program, and - emergency prep testing requirements. On February 27, 2024, at 8:17 a.m., LALD-C stated they updated part of the EPP last year with maintenance's assistance, and they were unaware of all the required content. LALD-C stated there is "a lot of information missing", and they were currently in the process of hiring a maintenance director. In addition, LALD-C stated	0 680		

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0 680	Continued From page 24 the EPP should be updated annually. On February 28, 2024, at 1:28 p.m., director of clinical services (DOCS)-S stated there was a binder that contained the EPP that directs staff which agency to contact. DOCS-S stated they encourage facilities to have a miniature plan at the front desk. DOCS-S stated a copy of the EPP was given to residents on admission, should contain contracts with sister sites, churches, anything about threats, global threats, domestic, and active shooter, and is a 200-page plan that goes through "A-Z". DOCS-S stated the EPP should be reviewed during the quality management meetings and evacuation routes should be posted in the elevators, apartments, front desk, nurses office and kitchen, and "should be everywhere". The licensees 7.01 Disaster Planning and Emergency Preparedness Plan dated January 1, 2017, indicated the licensee would have a written plan of action to facilitate the manage residents care and services in response to a natural disaster, or other emergencies that may disrupt their ability to provide care and services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730		

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0 730	Continued From page 25 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730		

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0 730	Continued From page 26 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 2, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses included multiple sclerosis, unspecified anxiety disorder, cellulitis, and gastro-esophageal reflux disease without esophagitis. R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments.	0 730		

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0 730	Continued From page 27 R2's Minnesota AL Comprehensive/Quarterly/12 Day Assessment dated January 25, 2024, and completed for a change of condition, indicated R2 required assistance to put on and take off TEDS (compression stockings). R2's electronic medication administration record/electronic treatment administration lacked any charting for TEDS. On February 28, 2024, at 12:43 p.m., clinical nurse supervisor (CNS)-D stated, "In the support action tab in RTasks her TEDS are listed in there, they put it (task to put on and take off TEDS daily) in but because this button (button labeled ISP) wasn't clicked, the aides are unable to see it on their task list and chart on it." The licensee's 5.01 Medication & Treatment Orders and Implementation policy, dated January 1, 2017, reads, "Documentation of specific client instructions relating to the administration of medications/treatments/therapy is located in the MAR/TAR and should be added to the Medications/Treatments/Therapy Management Plan. i. Documentation of completion of medications/treatments/therapy task should be completed at the time of service via electronic health record. ii. ULP will report client refusals to Licensed Nurse, the Licensed Nurse will provide instructions to ULP and/or speak with the client [resident]/responsible party/provider as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 780	Continued From page 28	0 780		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in 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 are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 29 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 28, 2024, at 11:00 a.m., survey staff toured the facility with maintenance supervisor (MS)-R. Survey staff tested the smoke alarms in multiple apartments. Upon testing, it was found that the smoke alarms in the following locations were not interconnected when the test button was pressed: 1. Apartment #311 2. Apartment #330 3. Apartment #223 4. Apartment #119 These deficient conditions were visually verified by MS-R accompanying on the tour. MS-R stated he didn't realize the smoke alarms had to be interconnected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 30 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 28, 2024, at 11:00 a.m., survey staff toured the facility with maintenance supervisor (MS)-R. It was observed that the portable fire extinguishers were tagged showing the required annual service date but lacked the records to show the required monthly visual inspections to date. All the fire extinguishers had documented monthly inspections for 8/23 and 9/23. During interview on February 28, 2024 at 1:00 p.m., survey staff explained to MS-R that the	0 790		

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0 790	Continued From page 31 portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by a staff member to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. MS-R verified the findings and stated that they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and 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.	0 800		

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0 800	Continued From page 32 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 28, 2024, at 11:00 a.m., survey staff toured the facility with maintenance supervisor (MS)-R. It was observed that the electrical panels in all of the hallways on all of the levels were not locked. The electrical panels inside the shop, garage, and storage room did not have the required clear floor space in front of them. Miscellaneous storage items were stacked in front of them or up against them obstructing access. It was observed that the trash chute doors on the third floor did not shut and latch on their own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed that apartment #206 was missing the transition strip between the bathroom floor and the living room floor. Flooring transition strips must be maintained to avoid tripping hazards and exposure of the subfloor to damage. It was observed that the exhaust fan in the restroom adjacent to the elevators next to the activities room on the first floor did not work. It was observed that the storage room door in the	0 800		

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0 800	Continued From page 33 activities center on the first floor was damaged at the bottom. The doors had entire parts of the bottom missing, up to four inches missing on the corners in both directions. During interview on February 28, 2024, at 1:00 p.m., MS-R stated he understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 34 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On February 28, 2024, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "7.05 Fire", dated 2017, failed to include the following:	0 810		

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0 810	Continued From page 35 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on February 28, 2024, at 2:00 p.m., LALD-C stated they understood some areas of their policy were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-C was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 36 Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-C was unable to provide documentation showing any training completed or training scheduled for a future date for employees on the fire safety and evacuation plan. During an interview on February 28, 2024, at 2:00 p.m., LALD-C stated they understood the areas of their training that were insufficient and would work on bringing them into compliance. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. LALD-C was unable to provide documentation showing any evacuation drills had been completed. During an interview on February 28, 2024, at 2:00 p.m., LALD-C stated there were no documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910		

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0 910	Continued From page 37 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of five residents (R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee began providing services under their assisted living facility license on August 1, 2021. R2 R2 was admitted on April 2, 2019, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's record included a Residency Agreement signed by R2's legal representative on March 22, 2019. R2 signed an addendum to the contract on April 26, 2022. R3	0 910		

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0 910	Continued From page 38 R3 was an independent resident at the licensee's facility. R3's record included an Assisted Living Contract signed by R3 on August 6, 2021. R3 signed an addendum to the contract on May 18, 2022. R4 R4 admitted on June 23, 2021, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's Assisted Living Contract was signed June 21, 2021. R4 signed an addendum to the contract on May 19, 2022. R5 R5 admitted on November 22, 2015, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R5's Assisted Living Contract was signed August 3, 2021. R5 signed an addendum to the contract on May 18, 2022. R2, R3, R4, and R5's written contracts lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On February 28, 2024, at 12:52 p.m., director of clinical services (DOCS)-S stated in August of 2021 the corporate office made a change to the contract because of the new assisted living regulations. DOCS-S stated the corporate office provided the contracts to the licensed assisted living directors and they were to distribute the	0 910		

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0 910	Continued From page 39 new contract to each resident who resided in the facility. On February 28, 2024, at 1:50 p.m., licensed assisted living director (LALD)-C stated they were aware the contract should contain the licensee's HFID. On February 28, 2024, at 2:12 p.m., office manager (OM)-F stated the licensee updated their contract in 2022, and residents who received a contract prior to 2022 received an addendum to the contract. The surveyor observed the addendum and observed no HFID written on the addendum. The surveyor inquired if R2, R3, R4, and R5 had any other contract. OM-F stated no. The licensee's 4.16 Content of Service Contract policy dated May 27, 2021, the licensee must review with the residents and/or their responsible party about the content of the contract in accordance with regulatory requirement of Minnesota Department of Health (MDH). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 40 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to	01060		

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01060	Continued From page 41 the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments. R2's progress notes dated, February 13, 2024, and February 17, 2024, indicated R2 was hospitalized from February 13, 2024, through February 17, 2024. R2's record lacked a written notice with the required statutory content provided to resident or resident representative of emergency relocation. On February 27, 2024, at 12:48 p.m., licensed assisted living director (LALD)- stated, "She [R2] does not have that [emergency relocation] form for those dates (February 13, 2024, through	01060		

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01060	Continued From page 42 February 17, 2024), it wasn't done. They [staff] tried to say technically it wasn't four days, but I told them yes it was." The Licensee's Emergency Relocation of Resident policy, dated August 1, 2021, read, "When resident goes to hospital, skilled nursing, or need emergency relocation the following step must be taken: -The notice must be delivered to the resident's case manager if the resident is receiving home and community-based waiver services. -The notice must also be delivered to the Office of Ombudsman for Long Term Care as soon as practicable and within 24 hours if the resident has relocated and not returned to the community within four days. -The notice must include the reason for the relocation, the name and contact information for the location and service provider where the resident is being relocated, and the contact information for the Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. -The notice must also include, if known and applicable, the estimated date or date range of when the resident is expected to return to the community. If the date or estimated date is not known, the notice must include a statement that the return date is not known." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 43 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for eight of eight employees (housekeeper (HK)-H, dietary (D)-I, D-L, D-M, unlicensed personnel (ULP)-G, ULP-J, ULP-K, licensed practice nurse (LPN)-E). This resulted in an immediate correction order issued on February 27, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include:	01290		

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01290	Continued From page 44 HK-H HK-H was hired on February 24, 2022, and provided housekeeping services to residents. HK-H's background study affiliated to licensee's health facility identification number (HFID) 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the Minnesota Department of Human Services NETStudy 2.0 website (a web-based system used to submit background study requests) roster page. HK-H's Individual Timecard indicated HK-H last worked February 23, 2024, from 10:00 a.m. until 6:00 p.m. D-I D-I hired on December 14, 2021, and provided food services to residents. D-I background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. D-I's Individual Timecard indicated D-I last worked January 27, 2024, from 10:21 a.m. until 1:23 p.m. D-L D-L hired on December 17, 2021, and provided food services to residents. D-L background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. D-L's Individual Timecard indicated D-L's last	01290		

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01290	Continued From page 45 worked February 26, 2024, from 3:52 p.m. until 6:37 p.m. D-M D-M hired on December 17, 2023, and provided direct care services to residents. D-M background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. D-M's Individual Timecard indicated D-M last worked February 26, 2024, from 3:52 p.m. until 6:37 p.m. ULP-G was hired on December 28, 2021, and provided direct cares and services to residents. ULP-G's background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. The licensee staffing schedule printed February 27, 2024, indicated ULP-G worked 7.5 hours on February 18, 2024. ULP-J ULP-J was hired on August 25, 2021, and provided direct cares and services to residents. ULP-J's background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. ULP-J's Individual Timecard indicated ULP-J last worked February 25, 2024, from 6:58 a.m. until 2:58 p.m.	01290		

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01290	Continued From page 46 ULP-K ULP-K was hired on April 9, 2023, and provided direct care services to residents. ULP-K's background study affiliated to HFID 21623, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. The licensee staffing schedule printed February 27, 2024, indicated ULP-K worked 7.5 hours on February 18, 2024. LPN-E LPN-E was hired on April 9, 2023, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. LPN-E was licensed by the Minnesota Board of Nursing on September 24, 2013. On February 27, 2024, at 7:16 a.m., surveyor observed LPN-E complete activities of daily living (ADLs) with R9. LPN-E's record lacked evidence that the licensee submitted a background study for LPN-E under the current assisted living license and affiliated to the current health facility identification (HFID) number. On February 27, 2024, at 8:04 a.m., the surveyor compared the facility's employee list to licensee's Minnesota (MN) Department of Human Services (DHS) NETStudy 2.0 roster for Health facility identification (HFID) 21623 and observed 22 employees; two LPNs, six ULP, ten dietary personnel, one social service person, one activities coordinator, and two concierge that lacked evidence the licensee submitted a	01290		

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01290	Continued From page 47 background study under the current assisted living license and affiliated to the current HFID number. On February 27, 2024, at 10:14 a.m., licensed assisted living director (LALD)-C stated they were not employed with the licensee during the COVID-19 period, and corporate office personnel were involved with background checks. The surveyor inquired if LALD-C was aware the COVID-19 background study had an expiration date. LALD-C stated they probably had an expiration date. On February 27, 2024, at 11:00 a.m., vice president (VP)-O stated they were aware the COVID eligible background study had an expiration date when performed, and the business office manager was in charge of the background checks. On February 27, 2024, at 11:02 a.m., office manager (OM)-F stated they were not employed at the assisted living facility (ALF) during the COVID-19 period, and were not aware the background study had an expiration date on them. On February 27, 2024, at 1:44 p.m., OM-F stated they were responsible for all staff having a current background study, and they have just started the duty of background studies in NETStudy 2.0 but had no experience with background checks. On February 27, 2024, at 2:13 p.m., OM-F stated the 22 staff members not listed in NETStudy 2.0 were separated from the NETSTudy 2.0 roster on November 21, 2021, and in order to see the staff on the NETStudy 2.0 roster, they would have to conduct another background study.	01290		

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01290	Continued From page 48 The licensee's 2.34 Background Checks policy dated 2017 indicated using the MN DHS NETStudy online program, the licensee would initiate a background study on all employees being considered for hire. Once background study has been received, staff may act independently with tenants or residents, assuming all other requirements have been met. On February 27, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help	01290		

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01290	Continued From page 49 section of NETStudy 2.0. No further information provided. TIME PERIOD FOR CORRECTION: Immediate On February 28, 2024, the immediacy of correction order 1290 was removed, however, non-compliance remained, and the scope and level remained unchanged.	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370		

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01370	Continued From page 50 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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel (ULP)-B). 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-B began working for the licensee April 9, 2023, and provided direct cares and services to residents. On February 27, 2024, at 7:13 a.m., the surveyor observed ULP-B administer oral medications to	01370		

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01370	Continued From page 51 R8. ULP-B's employee record lacked the following: - training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - 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; and - understanding appropriate boundaries between staff and residents and the resident's family. - competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On February 28, 2024, at 9:00 a.m., licensed assisted living director (LALD)-C inquired to the surveyor if EduCare (education software program) would contain the staff competencies. On February 28, 2024, at 9:07 a.m., the surveyor observed LALD-C and clinical nurse supervisor (CNS)-D search the director of nurse (DON) office for the staff competencies.	01370		

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01370	Continued From page 52 On February 28, 2024, at 9:17 a.m., CNS-D stated training ULPs was the following process: - ULPs completed EduCare training; - ULPs would shadow with another competent ULP; and - the registered nurse would complete competency evaluations on ULPs and sign documentation as proof the ULP was competent. On February 28, 2024, at 9:20 a.m., ULP-B stated they attended a class for medication administration but was not sure if a nurse completed competency evacuations on the topics listed above. On February 28, 2024, at 12:50 p.m., director of clinical services (DOCS)-S stated the licensee used EduCare for staff training and each staff member that provided direct resident care should have a competency evaluation for the topics listed above. DOCS-S stated the licensee had a binder for competencies located in the DON office or in each employee record. However, staff were never able to locate the binder or competencies. Licensees 3.04 Training and Competency Evaluations for Unlicensed Personnel policy dated December 29, 2016, indicated a registered nurse (RN) must ensure ULP were trained in the proper methods to perform tasks and procedures for each client [resident] and a copy of all education, training and competency testing shall be kept in employee's file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 53	01380		
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 observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel (ULP)-B). 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).	01380		

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01380	Continued From page 54 The findings include: ULP-B began working for the licensee April 9, 2023, and provided direct cares and services to residents. On February 27, 2024, at 7:13 a.m., the surveyor observed ULP-B administer oral medications to R8. ULP-B's employee record lacked documentation of signed competencies by the registered nurse for: - competency evaluations: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - administering medications or treatments as required; and - other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On February 28, 2024, at 9:00 a.m., licensed assisted living director (LALD)-C inquired to the surveyor if EduCare (education training program) would contain the staff competencies. On February 28, 2024, at 9:07 a.m., the surveyor observed LALD-C and clinical nurse supervisor (CNS)-D search the director of nurse (DON)	01380		

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01380	Continued From page 55 office for the staff competencies. On February 28, 2024, at 9:17 a.m., CNS-D stated training ULPs was the following process: - ULPs completed EduCare training; - ULPs would shadow with another competent ULP; and - the registered nurse would complete competency evaluations on ULPs and sign documentation as proof the ULP was competent. On February 28, 2024, at 9:20 a.m., ULP-B stated they attended a class for medication administration and were not sure if a nurse completed competency evaluations on the topics listed above. On February 28, 2024, at 12:50 p.m., director of clinical services (DOCS)-S stated the licensee used EduCare for staff training and each staff member that provided direct resident care should have a competency evaluation for the topics listed above. DOCS-S stated the licensee had a binder for competencies located in the DON office or in each employee record. However, staff were never able to locate the binder or competencies. Licensees 3.04 Training and Competency Evaluations for Unlicensed Personnel policy dated December 29, 2016, indicated a registered nurse (RN) must ensure ULP were trained in the proper methods to perform tasks and procedures for each client [resident] and a copy of all education, training and competency testing shall be kept in employee's file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01380		

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01380	Continued From page 56 (21) days	01380		
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 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	01470		

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01470	Continued From page 57 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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (unlicensed personnel (ULP)-P). 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:	01470		

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01470	Continued From page 58 ULP-P began employment with the licensee, under the comprehensive license and started providing assisted living services June 8, 2023. ULP-P's records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handing of resident complaints; - reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - orientation to each specific resident and services provided. On February 28, 2024, at 9:16 a.m., licensed assisted living director (LALD)-C stated the new hire training process was all staff that provided direct care would have EduCare (education software program) before providing services. On February 28, 2024, at 1:05 p.m., director of nursing services (DOCS)-S stated the training for staff was the responsibility of the LALD and clinical nurse supervisor (CNS) to ensure staff have the required training. The licensee's 3.01 Comprehensive Home Care Manual dated December 29, 2016, indicated staff would complete the orientation to home care requirements before providing home care services to clients. The policy provided was related to 144A, Comprehensive Home Care, not 144G, Assisted Living licensure. No further information was provided.	01470		

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01470	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure direct care staff received the appropriate amount of initial and annual	01530		

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01530	Continued From page 60 dementia care training in required topics for two of three employees (unlicensed personnel (ULP)-B, ULP-P). 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-B ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services April 9, 2023. ULP-B's EduCare transcript included four hours and fifteen minutes of dementia care training completed April 10, 2023. ULP-B's employee records lacked the initial eight (8) hours of dementia care training within 160 hours as required. ULP-P ULP-P began employment with the licensee, under the comprehensive license and started providing assisted living services June 8, 2023. ULP-P's EduCare transcript included four hours and thirty minutes of dementia care training completed June 24, 2023. ULP-P's employee records lacked the initial eight (8) hours of dementia care training within 160 hours as required.	01530		

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01530	Continued From page 61 On February 28, 2024, at 9:16 a.m., the licensed assisted living director (LALD)-C stated the new hire training process was all staff that provided direct care would have EduCare (education software program) before providing services. On February 28, 2024, at 1:05 p.m., the director of nursing services (DOCS)-S stated the training for staff was the responsibility of the LALD and clinical nurse supervisor (CNS) to ensure staff have the required training. The licensee's 3.01 Comprehensive Home Care Manual dated December 29, 2016, indicated staff would complete the orientation to home care requirements before providing home care services to clients. The policy provided was related to 144A, Comprehensive Home Care, not 144G, Assisted Living licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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	01620		

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01620	Continued From page 62 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for four of four residents (R1, R2, R4, R5). In addition, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptoms for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on January 15, 2022, and began	01620		

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01620	Continued From page 63 receiving assisted living services. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management, medication administration, laundry, and activities. R1's record indicated the RN completed ongoing 90-day assessments on October 2, 2023, and January 2, 2024, which indicated 93 days had passed between assessments. R2 R2 was admitted on April 2, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments. R2's progress notes dated, February 13, 2024, and February 17, 2024, indicate R2 was hospitalized from February 13, 2024, through February 17, 2024. R2's record indicated the RN completed ongoing 90-day assessments on August 7, 2023, and November 7, 2023, which indicated 93 days had passed between assessments. R2's most recent 90-day assessment was completed on January 25, 2024, which indicated R2's chart lacked a change in condition assessments after hospitalization.	01620		

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01620	Continued From page 64 On February 27, 2024, at 12:30 p.m. clinical nurse supervisor (CNS)-D stated, "I don't know the reason there is no assessments from her (R2) hospital return when she returned the first time (February 17, 2024) and that second hospital stay I believe was the RN's last day and she chose not to do it before she left." R4 R4 admitted on June 23, 2021, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's Service Plan (Wavier) - Addendum to Contract signed July 28, 2021, indicated R4 received assistance with blood glucose monitoring. The service plan lacked medication management services for R4. R4's record included ongoing 90-day assessments completed on November 3, 2023, and February 5, 2024, which indicated 95 days had passed between assessments. R5 R5 admitted on November 22, 2015, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R5's service plan signed February 6, 2023, indicated R5 received assistance with medication administration, laundry, blood glucose monitoring, and meals. R5's record indicated the RN completed ongoing 90-day assessments on November 7, 2023, and February 7, 2024, which indicated 92 days had passed between assessments.	01620		

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01620	Continued From page 65 On February 28, 2024, at 12:55 p.m., director of clinical services (DOCS)-S stated nursing assessments were completed preadmission, upon admission, day 14, every 90 days, and with significant changes. DOCS-S stated PointClickCare (PCC) (a documenting software program) generated quarterly assessments according to the calendar year and only could be changed if it was manually activated through the schedule. DOCS-S stated nursing attempted to open nursing assessments five days before they are due. The licensee's Nursing Assessment policy dated August 1, 2021, indicated ongoing resident assessments 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 assessment. No further information 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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01640	Continued From page 66 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of six residents (R4, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 admitted to the licensee for services on June 23, 2021, and began receiving assisted living services.	01640		

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01640	Continued From page 67 R4's diagnosis included paroxysmal atrial fibrillation (irregular heart rate), hypertension (HTN), age related osteoporosis with current fracture, sacroiliitis (inflammation of sacroiliac joint), insomnia, gastro-esophageal reflux disease (GERD), high cholesterol, chronic kidney disease stage 3, high potassium, diabetes mellitus type two, dementia, and major depressive disorder. R4's Service Plan (Wavier) - Addendum to Contract signed July 28, 2021, indicated R4 received assistance with blood glucose monitoring. The service plan lacked medication management services for R4. R4's medication administration record dated (MAR) dated February 1, 2024, through February 29, 2024, indicated staff administered the following medications to R4 on February 1, 2024, through February 26, 2024. - amlodipine besylate tablet 5 milligrams (mg); - cholecalciferol tablet 1000 mg; - melatonin tablet 10 mg; - metoprolol succinate extended-release (ER) tablet 100 mg; - metoprolol succinate ER tablet 200 mg; - multivitamin 1 tablet, and; - omeprazole 20 mg. R4's service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. R9 R9 admitted to the licensee on August 16, 2012, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021.	01640		

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01640	Continued From page 68 R9's diagnoses included congestive heart failure, anxiety disorder, major depression, dementia without behavioral disturbance, and respiratory failure with hypoxia. On February 27, 2024, from 7:16 a.m. to 7:48 a.m., the surveyor observed licensed practical nurse (LPN)-E provide activities of daily living (ADLs) to R9. The surveyor observed an ostomy bag on R9's right abdomen. R9 stated staff assisted with emptying contents of ostomy bag. On February 27, 2024, at 2:30 pm., licensed assisted living director (LALD)-C stated they were unable to locate a signed service plan for R9. LALD-C stated they believed the service plan was misplaced. The surveyor requested if the licensee had any note that this had been communicated to the resident and/or family. LALD-C stated they would look for the document. R9's unsigned service plan last review completed on March 2, 2021, indicated R9 received assistance with bathing, medications, ileostomy bag changes, escort to meals, dressing, mobility for long distances, toileting, and grooming. The service plan lacked daily cares to the ostomy bag and lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided. On February 28, 2024, at 1:05 p.m., director of clinical services (DOCS)-S stated the service plan was based off the resident assessment, created and reviewed by the LALD, nurse, and social worker, and then was presented to family to agree upon services the resident would receive. DOCS-S stated a signature, or a verbal	01640		

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01640	Continued From page 69 agreement would be obtained for the service to start. DOCS-S stated verbal agreement would be documented in a progress note or service notification. The surveyor did not receive documentation that the resident and/or resident's family member were in agreement on services to be provided prior to the end of survey. The licensee's 4.09 Contents of Service Plans dated August 1, 2021, indicated service plan and any revision to service plans would have a signature or other authentication by the facility and by the resident. Other authentication could be emailing confirmation accepting terms of a service agreement or other methods deemed appropriate by the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

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01730	Continued From page 70 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

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01730	Continued From page 71 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on January 15, 2022, and began receiving assisted living services. R1's diagnoses included hypertension (HTN), low back pain, chronic lymphocytic leukemia of B-cell type in remission, macular degeneration, interstitial pneumonitis, osteoarthritis of hip, shortness of breath, hypoxemia (abnormally low level of oxygen in the blood), and impaired fasting glucose. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management, medication administration, laundry, and activities. On February 27, 2024, at 8:48 a.m., the surveyor observed LPN-E administer oral medications to R1. R1's ongoing nursing assessment dated January 2, 2024, indicated R1's medications were administered by professional nursing staff or nurse delegation three times per day. R1's Medication/Treatment/Therapy Management Plan dated October 2, 2023, indicated monitoring of R1's medications, verification that all meds are carried out as prescribed, medication management tasks that may be delegated to the	01730		

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01730	Continued From page 72 ULP, and specific requirements related to documenting medication administration would be located on the clients [residents] medication administration record (MAR) and in the electronic medical record (EMAR) service tasks. The document included the following statements: - medications and medication/treatment/therapy supplies would be monitored and refills would be coordinated by; and - medications would be (select all that apply) related to medication storage. The statements listed above showed multiple options to choose from to individualize R1's medication management plan however, none of the options were addressed. R1's MAR dated February 1, 2024, through February 29, 2024, included diclofenac sodium 1 percent (%) topical apply to painful area topically two times a day for pain. The MAR lacked specific instructions on where to apply the diclofenac gel and how many grams (g) to apply. R1's medication management plan comprised of multiple documents lacked the following: - type of medication storage system, based on resident's needs; - person responsible for monitoring medication supplies and refills; and - specific written instructions for resident medication administration. The manufacturer's instructions for diclofenac sodium gel 1 % dated August 23, 2023, recommended the total dose of diclofenac sodium gel should not exceed 32 g per day, over all effected joints and the topical gel should be measured onto the enclosed dosing card to the appropriate 2 g or 4 g designation.	01730		

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01730	Continued From page 73 The licensee's Medication and Treatment Plans dated January 1, 2017, read, "The medication and treatment plan must include all of the following required elements: 1. A description of the medication and treatment services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences. 2. The identification of the type staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. 3. How the medication and treatment will be initiate 4. How the medication and treatment will be stored 5. Who will monitor the treatment and medication? 6. Communication to residents, family, and outside provider, to ensure any changes are communicated 7. Type of medication treatment services 8. When the medication treatment services will end 9. Coordination with outside provide must be initiate of the medication treatment plan 10. The schedule and methods of monitoring reviews or assessments of the resident. 11. The frequency of sessions of supervision of staff and type of personnel who will supervise staff." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01760	Continued From page 74	01760		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for two of four residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on January 15, 2022, and began	01760		

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01760	Continued From page 75 receiving assisted living services. R1's diagnoses included hypertension (HTN), low back pain, chronic lymphocytic leukemia of B-cell type in remission, macular degeneration, interstitial pneumonitis, osteoarthritis of hip, shortness of breath, hypoxemia (abnormally low level of oxygen in the blood), and impaired fasting glucose. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management at 2 liters (L), medication administration, laundry, and activities. On February 27, 2024, at 8:39 a.m., the surveyor observed licensed practical nurse (LPN)-A set up medications up for R1's morning medication pass. The surveyor observed LPN-A remove calcium 600 milligrams (mg) with D 10 microgram (mcg) from the medication cart, compare it to the electronic medication administration record (EMAR), and state "we are going to have to look upstairs but it is not the correct dose." LPN-A documented medication not administered. In addition, LPN-A stated there was no diclofenac gel for R1 and documented medication was not administered. R1's signed provider orders dated September 7, 2023, included calcium carbonate 600 mg - vitamin D 10 mcg take one tablet by mouth two times a day and diclofenac sodium gel 1 percent (%) apply 2 grams (g) to the painful area twice per day. R1's medication administration record (MAR) dated February 1, 2023, through February 29, 2024, instructed to administer calcium citrate 315	01760		

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01760	Continued From page 76 mg with vitamin D 250 units give one tablet two times per day. The medication was signed off 48 times in the month of February. In addition, the MAR included diclofenac sodium external 1 % topical, apply to painful area two times a day for pain. The MAR did not include the grams to be administered and was administered 28 times in the month of February. On February 27, 2024, at 8:57 a.m., the surveyor inquired how they would apply diclofenac sodium external 1% to R1. LPN-A stated if it was available, they would apply just a "tiny amount whatever covers the area." R5 R5 admitted on November 22, 2015, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R5's diagnoses included HTN, major depression, anxiety disorder, and diabetes mellitus type two. R5's service plan signed February 6, 2023, indicated R5 received assistance with medication administration, laundry, blood glucose monitoring, and meals. On February 27, 2024, at 7:49 a.m., the surveyor observed LPN-E apply gloves and complete blood glucose monitoring on R9. R9's blood glucose was 70 milligrams per deciliter (mg/dl). R5's signed provider orders dated February 12, 2024, included check blood glucose twice per day, fax blood glucose records to the provider monthly, for leave of absence (LOA) decrease evening dose from 12 units to 9 units, "This Rx for Glucagon is to be given for LOA, and for	01760		

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01760	Continued From page 77 nursing to administer for hypoglycemia BS (blood sugar) < (less than) 100. Two times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA." In addition, the provider orders included glucagon 1mg inject 1 pen by injection route as directed for low blood sugar every 24 hours as needed. R5's MAR dated February 1, 2024, through February 29, 2024, included check blood glucose twice per day, fax blood glucose records to the provider monthly, for LOA decrease evening dose from 12 units to 9 units, "This Rx for Glucagon is to be given for LOA, and for nursing to administer for hypoglycemia BS (blood sugar) < (less than) 100. Two times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA." In addition, the MAR included glucagon 1mg inject 1 pen by injection route as directed for low blood sugar every 24 hours as needed. R5's MAR indicated R5's blood glucose was under 100 mg/dl 11 times in the month of February and R5 received no glucagon in the month of February. On February 28, 2024, at 12:29 p.m., director of clinical services (DOCS)-S stated medications placed on the EMAR were what ULP were directed to administer. DOCS-S stated the right practice was the ULP were supposed to administer medications per the providers orders. Clinical nurse supervisor (CNS)-D stated the dose for diclofenac sodium 1% was not listed on the EMAR for R1. The licensee's 5.09 Medication Administration - Licensed Nurse policy dated October 13, 2018, indicated the medication administration procedure included follow the "6 rights" which included; - right person	01760		

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01760	Continued From page 78 - right medication - right time - right route - right dose - right chart/record to document that the medication was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of four residents (R4, R10). 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:	01830		

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01830	Continued From page 79 R4 R4 admitted on June 23, 2021, and began receiving assisted living services. R4's diagnosis included paroxysmal atrial fibrillation (irregular heart rate), hypertension, age related osteoporosis with current fracture, sacroiliitis (inflammation of sacroiliac joint), insomnia, gastro-esophageal reflux disease (GERD), high cholesterol, chronic kidney disease stage 3, high potassium, diabetes mellitus type two, dementia, and major depressive disorder. R4's Service Plan (Wavier) - Addendum to Contract signed July 28, 2021, indicated R4 received assistance with blood glucose monitoring. The service plan lacked medication management services for R4. R4's most recent provider orders for metformin 500 milligrams (mg) was signed on September 09, 2022, Eliquis 2.5 mg was signed on August 8, 2022, and calcium citrate 600 mg was signed on August 8, 2022. R4's medication administration record dated (MAR) dated February 1, 2024, through February 29, 2024, indicated staff administered the following medications to R4 on February 1, 2024, through February 26, 2024. - amlodipine besylate tablet 5 milligrams (mg); - cholecalciferol tablet 1000 mg; - melatonin tablet 10 mg; - metoprolol succinate extended-release (ER) tablet 100 mg; - metoprolol succinate ER tablet 200 mg; - multivitamin 1 tablet, and; - omeprazole 20 mg.	01830		

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01830	Continued From page 80 R10 R10 admitted on March 17, 2022, and began receiving assisted living services. R10's diagnoses included, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, hypertension (HTN), spinal stenosis (spinal column narrows and compresses the spinal cord) of the cervical region, disorder of the autonomic nervous system, and peripheral autonomic neuropathy. R10's service plan signed March 18, 2022, indicated R10 received assistance with medication administration, transfers, grooming, dressing, toileting, bathing, oxygen, and wheelchair mobility. In addition, R10 received physical and occupational services. R10's most recent provider orders for ten medications were signed on March 15, 2022. On February 27, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated they did not have recent signed provider orders for R4 and R10. On February 28, 2024, at 1:23 p.m., clinical nurse supervisor (CNS)-D stated medication orders should be renewed every three months. Director of clinical services (DOCS)-S stated medication orders should be renewed at least every 12 months and as needed. The licensee's 5.01 Medication & Treatment Orders policy dated August 1, 2021, indicated the licensed nurse would communicate with the prescriber to assure the prescriber renews a medication or treatment order at least every 12 months, or more frequently as needed.	01830		

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01830	Continued From page 81 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for two of three residents (R5, R14). In addition, the licensee failed to store all prescription medications securely to permit only authorized personnel to have access. 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 the residents). The findings include: MANUFACTURER'S DIRECTIONS On February 26, 2024, at 9:43 a.m., the surveyor	01880		

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01880	Continued From page 82 observed the medication refrigerator at 29.1 degrees Fahrenheit (F) and observed the following medications within: -R5's two unopened boxes that contained five Lantus SoloStar insulin pens in each box, and three NovoLog Mix 70/30 insulin pens. -R14's four acetaminophen (apap) 650 milligram (mg) rectal suppositories. Licensee's document titled Medication Room Record of Refrigeration Temperatures dated February 2024, indicated the medication refrigerator was below 36 degrees F eight times from February 1, 2024, through February 27, 2024. The document also indicated the refrigeration temperature should not be greater than 40 degrees F and the freezer should not be greater than 0 degrees F. On February 26, 2024, at 9:52 a.m., licensed practical nurse (LPN)-A stated the licensee liked the medication refrigerator to be around 36 degrees F. LPN-A stated, "it has gone down it was 43 degrees this morning. LPN-A stated they would call maintenance for repair of the medication refrigerator to get the temperature into range. The surveyor inquired who had access to the medication refrigerator. LPN-A stated the nurse and some of the ULP because they would have to have access to get more medications for the medication passes. On February 28, 2024, at 1:14 p.m., director of clinical services (DOCS)-S stated the medication refrigerator should be kept between 41 and 43 degrees F. Clinical nurse supervisor (CNS)-D stated the medication refrigerator should be kept between 36 and 41 degrees F. DOCS-S stated there was a medication refrigerator log to document employees looking at the refrigerator	01880		

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01880	Continued From page 83 temperature. DOCS-S stated if the refrigerator temperature was out of range staff would adjust the temperature. CNS-D stated the log should reference the appropriate temperature range and indicate when the refrigerator should be adjusted. The surveyor showed CNS-D the medication refrigerator log and inquired if it listed a temperature range. CNS-D stated no, there was no minimum listed. The manufacturer's instructions for Lantus SoloStar insulin pen dated 2020 recommended unopened insulin pens be stored in a cool storage with a temperature range between 36 degrees F and 46 degrees F until opened. The manufacturer's instructions for NovoLog Mix 70/30 insulin pen dated 2023 recommended unused insulin pens be stored in a refrigerator with the temperature range set between 36 degrees F and 46 degrees F. Do not freeze insulin pens and if frozen discard insulin pens. The manufacturer's instructions for apap suppositories 650 mg read, "store at 20-25°C [Celsius] (68-77°F) or in a cool place." The licensee's 5.13 Storage of Medication policy dated January 1, 2017, indicated medications shall be stored consistent with manufacturer's recommendations. In addition, employees were to report any temperatures below 36 degrees or higher than 46 degrees to the nursing supervisor. UNSECURED MEDICATIONS On February 27, 2024, from 7:10 a.m. through 7:48 a.m., the surveyor observed a tote that contained one Lantus SoloStar pen, and a glucagon kit for R5 in the common living area on the first floor to be left unattended while LPN-E	01880		

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01880	Continued From page 84 attended to other tasks throughout the facility. During this time, two staff members, one from food service and one from housekeeping entered the room, having access to these medications. On February 27, 2024, at 8:20 a.m., LPN-E stated they were trained to store medications upstairs in the medication room or in the carts. The surveyor inquired why R5's medications were left unlocked and unsecured. LPN-E stated it was left out by accident because someone put on their pendant for assistance. LPN-E stated they were trained to put it "away". The surveyor asked where the location would be. LPN-E stated it belonged upstairs in the medication room. On February 28, 2024, at 8:25 a.m., the surveyor observed the first-floor medication cart which contained six resident's medications unlocked and unsecured for three minutes. R10 was sitting in the common living area eating breakfast. On February 28, 2024, at 8:29 a.m., ULP-P stated they forgot to lock the medication cart when a resident called for assistance and they "rushed to her." On February 28, 2024, at 1:19 p.m., DOCS-S stated medication carts should be locked at all times when not in use and medications were not allowed to be left unsecured. The licensee's 5.13 Storage of Medication policy dated January 1, 2017, indicated medications managed outside of a client's [resident's] private living space must be securely locked in substantially constructed compartments and only authorized personnel would have access to the medications.	01880		

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01880	Continued From page 85 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for four of twelve residents (R1, R5, R6, R9). 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 the residents). The findings include: On February 26, 2024, at 9:43 a.m., the surveyor observed the medication refrigerator and observed R5's three NovoLog Mix 70/30 insulin pens with an expiration date of January 31, 2024.	01890		

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01890	Continued From page 86 On February 26, 2024, at 10:12 a.m., the surveyor observed the first-floor medication cart one and observed the following expired medications: - one ventolin hydrofluoroalkane 90 micrograms (mcg) with an expiration date of January 11, 2022, and one bottle of hydrocortisone 2.5 percent (%) cream with an expiration date of January 24, 2022, for R9. On February 26, 2024, at 10:18 a.m., the surveyor observed the first-floor medication cart two, and observed one bottle of amlodipine 5 milligrams (ml) with an unknown number of pills inside for R1 with a label that read "discard by November 10, 2023". On February 26, 2024, at 10:47 a.m., the surveyor observed the second-floor medication cart and observed one bottle of latanoprost 0.005% eye drop opened without a date open label for R6. On February 28, 2024, at 1:18 p.m., clinical nurse supervisor (CNS)-D stated time sensitive medication should be labeled with the date opened because some time sensitive medications needed to be disposed of 28 days after opening. CNS-D stated ULP were trained to bring expired medication to nursing to dispose of it. The manufacturer's instructions for latanoprost eye drop dated August 2011 recommended once an eye drop bottle was opened it may be stored at room temperature up to six weeks. The licensee's 5.17 Disposal of Medication policy dated January 1, 2017, indicated expired medications managed by the home care provider	01890		

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01890	Continued From page 87 [assisted living facility] would be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

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01940	Continued From page 88 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for four of four residents (R1, R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on January 15, 2022, and began receiving assisted living services. R1's diagnoses included hypertension (HTN), low back pain, chronic lymphocytic leukemia of B-cell type in remission, macular degeneration, interstitial pneumonitis, osteoarthritis of hip, shortness of breath, hypoxemia (abnormally low level of oxygen in the blood), and impaired fasting glucose. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management at 2 liters (L), medication administration, laundry, and	01940		

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01940	Continued From page 89 activities. On February 27, 2024, at 8:48 a.m., the surveyor observed R1 receiving 2.5 L of oxygen via nasal cannula by use of an oxygen concentrator. R1's Minnesota AL Comprehensive/Quarterly/14 Day Assessment dated January 2, 2024, indicated R1 used 2-4 L of oxygen and required oxygen monitoring continuously. R1's service check off list dated February 1, 2024, through February 29, 2024, lacked information related to oxygen management. R1's medication administration record (MAR) dated February 1, 2024, through February 29, 2024, included change oxygen tubing every two weeks and check resident's oxygen tank every shift and fill if escorting to activities. The MAR lacked information related to how much oxygen the R1 was receiving and lacked oxygen administration instructions. R1's Weights and Vital Summary dated February 26, 2024, indicated from January 15, 2022, through March 5, 2023, R1 oxygen saturation levels were between 60 and 98 percent (%), R1 was on oxygen 37 times while oxygen saturations were taken. The record lacked further oxygen saturation levels after March 5, 2023. R1's Medication/Treatment/Therapy Management Plan dated October 2, 2023, lacked oxygen management. R1's individualized treatment management plan comprised of multiple records lacked the following: - written instructions for each treatment or	01940		

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01940	Continued From page 90 therapy; - a list of the treatment or therapy tasks delegated to the ULP; - procedures to notify an RN or other licensed health professional (LHP) when problems arose with oxygen management; and - resident-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions. On February 28, 2024, at 12:38 p.m., director of clinical services (DOCS)-S stated oxygen documentation would be located on the MAR or the support action tab in RTasks (a documenting software program). Clinical nurse supervisor (CNS)-D stated a button was not clicked so the ULP were unable to document on this task. R2 R2 was admitted on April 2, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses included multiple sclerosis, unspecified anxiety disorder, cellulitis, and gastro-esophageal reflux disease without esophagitis. R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments. R2's Minnesota AL Comprehensive/Quarterly/12	01940		

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01940	Continued From page 91 Day Assessment dated January 25, 2024, and completed for a change of condition, indicated R2 required assistance to put on and take off TEDS. R2's electronic medication administration record/electronic treatment administration lacked the following required content for TED stocking application: - resident specific instructions related to the treatments/therapy administration; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions. On February 28, 2024, at 12:43 p.m., CNS-D stated, "In the support action tab in RTaks her [R2] TEDS are listed in there, they put it (task to put on and take off TEDS daily) in but because this button (button labeled ISP) wasn't clicked the aides are unable to see it on their task list and chart on it." On February 28, 2024, at 12:44 p.m., DOCS-S stated, "I don't see it listed though when to update a nurse or specifics so that will also need to be added." R4 R4's Service Plan (Wavier) - Addendum to Contract signed July 28, 2021, indicated R4 received assistance with blood glucose monitoring. R4's Medication/Treatment/Therapy record dated February 1, 2024, through February 29, 2024,	01940		

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01940	Continued From page 92 indicated R4 received blood glucose monitoring twice daily on Monday, Wednesday, and Friday. In addition, the plan indicated R4's specific client [resident] instructions related to the administration of medications/treatments/therapy was located on the client [resident] MAR/TAR. R4's MAR dated February 1, 2024, through February 29, 2024, included blood glucose checks twice daily on Monday, Wednesday, and Friday. The MAR lacked parameters when to contact the licensed health care professional when blood glucose levels were high or low. R4's individualized treatment management plan comprised of multiple records lacked the following: - process for notifying an RN or appropriate licensed health professional when an issue or concern arises with blood glucose monitoring. On February 28, 2024, at 1:21 p.m., DOCS-S stated the specific instructions should be written on the electronic medical administration record (EMAR) which should include "support action, depending on what the treatment was." R5 R5 admitted on November 22, 2015, under the licensee's previous comprehensive home care license and began receiving assisted living services on August 1, 2021. R5's diagnoses included HTN, major depression, anxiety disorder, and diabetes mellitus type two. R5's service plan signed February 6, 2023, indicated R5 received assistance with medication administration, laundry, blood glucose monitoring, and meals.	01940		

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01940	Continued From page 93 On February 27, 2024, at 7:49 a.m., the surveyor observed LPN-E apply gloves and complete blood glucose monitoring on R9. R9's blood glucose was 70 milligrams per deciliter (mg/dl). R5's Medication/Treatment/Therapy Plan dated June 7, 2023, indicated R5 received blood glucose monitoring and staff would notify a licensed nurse or appropriate licensed health professional when a problem arose with medication/treatment/therapy management services, including refusals and potential medication inaccuracies. Specific parameters regarding medications were also located on the client [resident] treatment administration record (TAR)/MAR. R5's MAR dated February 1, 2024, through February 29, 2024, included fax blood glucose record every four weeks to the provider, check blood glucose twice a day, glucagon is to be given for leave of absence and for nursing to administer for hypoglycemia blood glucose less than 100 mg/dl. In addition, the MAR indicated R5's blood glucose was under 100 mg/dl 11 times in the month of February. The MAR/TAR lacked parameters on when to contact a licensed health professional when blood glucose was low or high. R5's individualized treatment management plan comprised of multiple records lacked the following: - process for notifying an RN or appropriate licensed health professional when an issue or concern arises with blood glucose monitoring. On February 28, 2024, at 12:36 p.m., DOCS-S stated instructions for when a ULP should contact a nurse for low or high blood glucose levels	01940		

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01940	Continued From page 94 should be located on the MAR or support action tab in RTasks. CNS-D verified R5's treatment plan lacked when to contact a LHP if a concern arose with blood glucose monitoring. The licensee's 5.01 Medication & Treatment Orders and Implementation policy, dated January 1, 2017, reads, "Documentation of specific client instructions relating to the administration of medications/treatments/therapy is located in the MAR/TAR and should be added to the Medications/Treatments/Therapy Management Plan. i. Documentation of completion of medications/treatments/therapy task should be completed at the time of service via electronic health record. ii. ULP will report client refusals to Licensed Nurse, the Licensed Nurse will provide instructions to ULP and/or speak with the client [resident]/responsible party/provider as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered	01960		

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01960	Continued From page 95 and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for two of four residents (R1, R2). In addition, the licensee failed to ensure treatments were performed as ordered for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on January 15, 2022, and began receiving assisted living services. R1's diagnoses included hypertension (HTN), low back pain, chronic lymphocytic leukemia of B-cell type in remission, macular degeneration, interstitial pneumonitis, osteoarthritis of hip, shortness of breath, hypoxemia (abnormally low level of oxygen in the blood), and impaired fasting glucose. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management at 2 liters	01960		

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01960	Continued From page 96 (L), medication administration, laundry, and activities. On February 27, 2024, at 8:48 a.m., the surveyor observed R1 receiving 2.5 L of oxygen via nasal cannula by use of an oxygen concentrator. Licensed practical nurse (LPN)-A checked the oxygen level setting on the oxygen concentrator. R1 stated the staff assisted her with oxygen use. R1's Minnesota AL Comprehensive/Quarterly/14 Day Assessment dated January 2, 2024, indicated R1 used 2-4 L of oxygen and required oxygen monitoring continuously. R1's Weights and Vital Summary dated February 26, 2024, indicated from January 15, 2022, through March 5, 2023, R1's oxygen saturation levels were between 60 and 98 percent (%), R1 was on oxygen 37 times while oxygen saturations were taken. The record lacked further oxygen saturation levels after March 5, 2023. R1's medication administration record (MAR) dated February 1, 2024, through February 29, 2024, included change oxygen tubing every two weeks and check resident's oxygen tank every shift and fill if escorting to activities. The MAR lacked the following documentation: - if R1 received oxygen; - how oxygen was administered; - the amount of oxygen in L R1 received; and - who administered and monitored the oxygen. On February 28, 2024, at 12:38 p.m., director of clinical services (DOCS)-S stated oxygen documentation would be located on the MAR or the support action tab in RTasks (a documenting software program). Clinical nurse supervisor (CNS)-D stated a button was not clicked so the	01960		

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01960	Continued From page 97 ULP were unable to document on this task. R2 R2 was admitted on April 2, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses included multiple sclerosis, unspecified anxiety disorder, cellulitis, and gastro-esophageal reflux disease without esophagitis. R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments. R2's Minnesota AL Comprehensive/Quarterly/12 Day Assessment dated January 25, 2024, and completed for a change of condition, indicated R2 required assistance to put on and take off TEDS. R2's electronic medication administration record/electronic treatment administration lacked any charting for TEDS. On February 28, 2024, at 12:43 p.m., the clinical nurse supervisor (CNS)-D stated, "In the support action tab in RTasks her [R2] TEDS are listed in there, they put it (task to put on and take off TEDS daily) in but because this button (button labeled ISP) wasn't clicked the aides are unable to see it on their task list and chart on it." The licensee's 5.01 Medication & Treatment Orders and Implementation policy, dated January	01960		

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01960	Continued From page 98 1, 2017, reads, "Documentation of specific client instructions relating to the administration of medications/treatments/therapy is located in the MAR/TAR and should be added to the Medications/Treatments/Therapy Management Plan. i. Documentation of completion of medications/treatments/therapy task should be completed at the time of service via electronic health record. ii. ULP will report client refusals to Licensed Nurse, the Licensed Nurse will provide instructions to ULP and/or speak with the client [resident]/responsible party/provider as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber's orders were in place for treatments for one of four residents (R1).	01970		

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01970	Continued From page 99 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on January 15, 2022, and began receiving assisted living services. R1's diagnoses included hypertension (HTN), low back pain, chronic lymphocytic leukemia of B-cell type in remission, macular degeneration, interstitial pneumonitis, osteoarthritis of hip, shortness of breath, hypoxemia (abnormally low level of oxygen in the blood), impaired fasting glucose. R1's service plan signed June 1, 32 (sic), indicated R1 received assistance with bathing, escort to meals, oxygen management at 2 liters (L), medication administration, laundry, and activities. On February 27, 2024, at 8:48 a.m., the surveyor observed R1 receiving 2.5 L of oxygen via nasal cannula by use of an oxygen concentrator. R1's record lacked a prescriber order for R1's oxygen treatment. On February 28, 2024, at 1:48 a.m. licensed assisted living director (LALD)-C provided the surveyor a document that contained information requested by the surveyor. LALD-C indicated in	01970		

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01970	Continued From page 100 writing they did not have evidence of a R1's prescriber order for oxygen. On February 28, 2024, at 1:23 p.m., clinical nurse supervisor (CNS)-D stated treatment orders should be renewed every three months. Director of clinical services (DOCS)-S stated medication orders should be renewed at least every 12 months and as needed. The licensee's 5.01 Medication & Treatment Orders policy dated August 1, 2021, indicated the licensed nurse would communicate with the prescriber to assure the prescriber renews a medication or treatment order at least every 12 months, or more frequently as needed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	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 provide care and services according to acceptable health care, medical or nursing standards for two of five residents (R2, R10) with hospital-style bed rails.	02310		

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02310	Continued From page 101 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 had diagnoses to include multiple sclerosis, cellulitis, and anxiety disorder, unspecified. R2's unsigned Service Plan dated February 17, 2023, indicated R2 received assistance as needed with maintaining personal cleanliness related to indwelling catheter, set up and supervision of shower once a week, laundry, assistance with dressing, and assistance to apply protective garments. On February 26, 2024, at 10:30 a.m., unlicensed personnel (ULP)-B stated [R2] uses her bed rails every day because "she is too weak and needs them." On February 27, 2024, at 10:26 a.m., the surveyor observed R2's bed had bilateral (two sides) half rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. R2's record included a Device Evaluation for body pillows/positioning pillows and trapeze bar dated February 1, 2023, as well as a signed Managed Risk Agreement dated, February 1, 2023, that read, "Complete assessment done and no issues	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21623	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

(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
02310	Continued From page 102 or concerns at this time" and "continue to use grab bar and trapeze for mobility." R2's record lacked: -Device Evaluation for hospital bed rails; -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; -Documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; and -Documentation of the bed rail zones of entrapment measurements. R10 R10 had diagnoses of spinal stenosis, chronic obstructive pulmonary disease with (acute) exacerbation, muscle weakness (generalized), hypertension, shortness of breath, and dependence on supplemental oxygen. R10's unsigned Service Agreement dated March 10, 2022, indicated R10 received transfer assistance, bathing, bathroom assistance, one assist for bed mobility as needed, dressing, and laundry. On February 27, 2024, at 8:35 a.m., the surveyor observed R10 had bilateral (two sides) half rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. R10's record included a Managed Risk Agreement dated, December 6, 2022, that read, "Device assessment completed and noted grab bar is safe to use."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21623	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

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02310	Continued From page 103 R10's record lacked: -Device Evaluation for hospital bed rails; -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; -Documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; and -Documentation of the bed rail zones of entrapment measurements. On February 27, 2024, at 10:57 a.m., licensed assisted living director (LALD)-C stated, "Those are the only device assessments, back then it would have been [registered nurse (RN)-N], now we have the LPN check them, because [RN-N] is very very part time now but back then when those assessments were done, she is the one who would have done it. I don't know how often she follows up on bed rails, but I know there is nothing else documented for any of them." On February 27, 2024, at 2:40 p.m., clinical nurse supervisor (CNS)-D stated, "Normally we would need an order for the bed rails, and we have to do the assessment and educate the resident and have them assessed for appropriateness. We do the bed rail assessments, I think once a year. It's hard because this is not my building, so I don't know that much. I got called in after [RN-N] because she was supposed to be on call until they get a new RN, but she has not been returning anyone's calls, so they brought me over to this building." On February 27, 2024, at 2:53 p.m., LALD-C stated that nobody had heard back from RN-N and a couple people had reached out.	02310		

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	21623	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERS MANOR	3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422

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02310	Continued From page 104 The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21623	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 105 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 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 4.19 Siderails policy dated January 1, 2017, read, "When [licensee] is aware a home care client is utilizing siderails (a medical device) on a bed, [licensee] shall assess the use, educate the client, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use is of a safe design and utilized consistent with the manufacturer's directions." No further information was provided.	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 106 TIME PERIOD FOR CORRECTION: Immediate On February 28, 2024, the immediacy of correction order 2310 was removed, however, non-compliance remained, and the scope and level remained unchanged. In addition, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R10) who utilized oxygen. The findings include: On February 27, 2024, at 8:01 a.m., during facility tour, the surveyor observed one oxygen concentrator, two secured oxygen cylinders, and three unsecured oxygen cylinders that were not stored properly in noncombustible racks in R10's apartment. On February 27, 2024, 8:15 a.m., licensed practical nurse (LPN)-E stated oxygen was delivered by an oxygen company to the resident's room, stored in the resident's room, and staff where responsible for ensuring the oxygen cylinders or tanks were stored safe and upright. On February 27, 2024, at 1:09 p.m., director of clinical services (DOCS)-S stated oxygen cylinders should be stored in a safe area, upright, and in a stand in the resident's room. The licensee's undated 5.30 Oxygen policy indicated oxygen cylinder and vessels must remain upright at all times. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with	02310		

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02310	Continued From page 107 chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *02/27/24*
Time: 10:30:00
Report: 1005241057

Food and Beverage Establishment Inspection Report

Location:
Heathers Manor
3000 North Douglas Drive
Crystal, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037868
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635446777
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
TEST STRIPS FOR QUATERNARY AMMONIUM EXPIRED IN 2021. PROVIDE A NEW TEST KIT.
Comply By: 03/05/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
THERE WAS 0 PPM QUAT PRESENT IN THE WIPING CLOTH BUCKET BECAUSE THE DISPENSER IS NOT WORKING PROPERLY. MIX SANITIZER BY HAND TO 200-400 PPM QUAT UNTIL DISPENSER IS REPAIRED.
Comply By: 02/27/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
THE QUAT DISPENSER IS NOT PULLING SANITIZER AND WAS DISPENSING NEAR 0 PPM. MIX SANITIZER BY HAND UNTIL DISPENSER IS REPAIRED.
Comply By: 03/05/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/BUTTER
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/NOODLES
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BEEF
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 36 Degrees Fahrenheit - Location: TRUE REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/HAMBURGER
Temperature: 35 Degrees Fahrenheit - Location: TRUE REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: COLD WELLS
Violation Issued: No

Process/Item: Cold Hold/TOMATO
Temperature: 38 Degrees Fahrenheit - Location: COLD WELLS
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/NOODLES
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 35 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: NORLAKE REACH-IN COOLER
Violation Issued: No

Type: Full
Date: *02/27/24*
Time: 10:30:00
Report: 1005241057
Heathers Manor

Food and Beverage Establishment Inspection Report

Process/Item: Re-Heating/SOUP
Temperature: 184 Degrees Fahrenheit - Location: STOVETOP
Violation Issued: No

Process/Item: Hot Hold/AU JUS
Temperature: 193 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 179 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

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

INSPECTION COMPLETED WITH MANAGER AND REVIEWED WTIH HRD NURSE EVALUATOR KEITH LANGLEY.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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 1005241057 of 02/27/24.

Certified Food Protection Manager: ERIC D. PETERSON

Certification Number: FM31273 Expires: 03/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

ERIC PETERSON
KITCHEN MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us