DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 7, 2023

Licensee
Comfort Residence Le Sueur
105 Plum Run Road
Le Sueur, MN 56058

RE: Project Number(s) SL30477015

Dear Licensee:

On January 20, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 17, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

December 9, 2022

Administrator
Comfort Residence Le Sueur
105 Plum Run Road
Le Sueur, MN 56058

RE: Project Number(s) SL30477015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program $3,000
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $9,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30477	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 30477015 On November 14, 2022, through November 17, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 24 residents, all of whom received services under the provider's Assisted Living license. 0510: An immediate correction order was issued on November 14, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 2070: An immediate correction order was issued on November 14, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 2310: An immediate correction order was issued	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 on November 16, 2022. The immediacy was removed; however, non-compliance remains at a level 3, pattern scope (H).	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a 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; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	0 250		

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0 250	Continued From page 2 survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under 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).	0 250		

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0 250	Continued From page 3 The findings include: During the entrance conference on November 14, 2022, at 10:30 a.m., licensed assisted living director (LALD)-A 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.	0 250		

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0 250	Continued From page 4 - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which 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	0 250		

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0 250	Continued From page 5 operation of the facility, regardless of the existence of a management agreement or subcontract. - 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 the licensee on May 19, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of August 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (4) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or	0 250		

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0 250	Continued From page 6 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; (5) infection control practices; (6) medication and treatment management; As a result of this survey, the following orders were issued 0510, 0620, 0650, 1370, 1380, 1610, 1620, 1700, 1760, 1770, 1890, 3000, 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		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 7 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents, staff, and any 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: The licensee held an assisted living facility license, was licensed for a capacity of 37 residents and at the time of the survey had a census of 24 residents. The licensee failed to post a current staffing schedule.	0 470		

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0 470	Continued From page 8 On November 14, 2022, at 11:30 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed a bulletin board on the wall outside of LALD-A's office in the foyer of the facility. There was a form identified as a "block schedule" that included staff names, shifts/hours, and work location for a two-week time period; however, the form did not identify the date and had multiple blank shifts. LALD-A stated the block schedule posted was not accurate or reflective of the daily staffing schedule. LALD-A stated the daily staffing schedule was usually posted on the bulletin board, but confirmed it was not there. On November 14, 2022, at 1:21 p.m. scheduler (S)-J stated she completed the staff schedule but did not post it anywhere publicly. S-J indicated she was not aware it was a requirement. The licensee's Staffing, Direct-Care Staffing Plan, & Daily Schedule policy undated, noted the daily work schedule would be posted in a central location, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks	0 480		

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0 480	Continued From page 9 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 10	0 510		

complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. This had the potential to affect all residents, staff, and visitors. This resulted in an immediate correction order on November 14, 2022, at 3:42 p.m.

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

The findings include:

On November 14, 2022, at 10:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated the facility currently had two residents who had tested positive for COVID-19: R6 and R7.

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	30477	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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
0 510	Continued From page 11 On November 14, 2022, at 11:30 a.m. during the tour of the facility with LALD-A, surveyors observed a cart outside of room 107 containing hand sanitizer, disposable gowns and gloves, surgical masks and face shields. There was signage on the door indicating the resident was in isolation. LALD-A verified R6 resided in room 107. There were no N95 face masks observed on the cart. On November 14, 2022, at 3:12 p.m. unlicensed personnel (ULP)-E was observed entering room 107. ULP-E had donned personal protective equipment (PPE); a disposable gown, gloves, surgical mask, and a reusable face shield. At 3:15 p.m., ULP-E exited room 107 and continued to wear the PPE. ULP-E doffed the face shield and set it down on the cart outside of the resident's room on top of a stack of clean disposable gowns without disinfecting it first. ULP-E removed her mask and gloves, then grabbed the front sides of the gown and tore it off of her body. ULP-E then disposed of the contaminated PPE in the covered garbage container outside of the resident's room. When interviewed at that time, ULP-E confirmed the facility had not offered N95 masks for use in the COVID positive resident rooms. ULP-E cleansed her hands with hand sanitizer after disposing the PPE, then donned clean PPE and stated she was going into R7's room next, as she was also COVID positive. On November 14, 2022, at 3:42 p.m. registered nurse (RN)-B confirmed the facility had N95 masks available for ULP to utilize when going into a resident room who was COVID positive. RN-B further confirmed the staff should be wearing an N95 mask when entering the room of a COVID	0 510		

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0 510	Continued From page 12	0 510		

positive resident. The surveyor stated room 107 had a covered garbage container sitting outside of R6's room, and had observed the ULP doff PPE outside of the resident's room and discard into the garbage container in the hallway. The surveyor asked if the ULP do the same thing when exiting R7's room (room 104) as there was no garbage container observed outside of the room. RN-B didn't know and looked to LALD-A for confirmation. LALD-A stated she thought the ULP discarded the PPE in R7's room but wasn't sure.

On November 14, 2022, at 3:52 p.m. ULP-F stated they didn't have N95 masks and always had used just a surgical mask when entering a room with a COVID positive resident. ULP-F confirmed always removing PPE in the hallway and disposing in the garbage container outside of room 107.

On November 14, 2022, at 4:00 p.m. ULP-E stated the facility didn't have any N95 masks that she was aware of, and further stated she had never worn an N95 mask. ULP-E confirmed when exiting a COVID positive resident room, she always disposed of the contaminated PPE in the garbage container in the hallway.

The licensee's CDC (Center of Disease Control) guideline titled, How to Safely Remove Personal Equipment (PPE) undated, pertaining to doffing PPE indicated to remove all PPE before exiting the patient's room.

Minnesota Department of Health COVID-19 Source Control (Masking, PPE, and Testing Grid) dated November 2, 2022, identified a resident with a positive COVID-19 test requires full COVID-19 PPE: respirator, eye protection,

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0 510	Continued From page 13 isolation gown, and gloves. TIME PERIOD FOR COMPLETION: Immediate. On November 16, 2022, the immediacy of correction order 0510 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 14 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: On November 14, 2022, at 10:30 a.m. during the entrance conference with licensed assisted living director (LALD)-A, the surveyor made a request to review documentation of the licensee's quality management activities. LALD-A stated she would look for documentation but didn't think there had been a formal meeting for at least one year. On November 17, 2022, at 11:55 a.m. LALD-A stated she did not have any documentation of meeting minutes to provide. The licensee's Quality Management Plan policy dated July 28, 2021, noted the LALD would establish a quality management program to develop and maintain the licensee's continuous performance improvement efforts. The quality council meetings would be held at least quarterly to evaluate the quality of care. Documentation of meetings would be retained for two years and made available to the commissioner at the time of survey, investigation, or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		

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0 620	Continued From page 15	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included Alzheimer's disease and major depressive disorder. R5's Vulnerability Safety Risk assessment dated August 23, 2022, indicated the resident was inconsistent with reporting issues due to forgetfulness. Staff to provide reminders and	0 620		

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0 620	Continued From page 16 cuing, and also monitor for any signs of abuse. During the entrance conference on November 14, 2022, at 10:30 a.m. licensed assistant living director (LALD)-A indicated R5 had been taken to the hospital last evening due to a fall and subsequently was diagnosed with a urinary tract infection. LALD-A stated the police called the facility because hospital staff had notified them that R5 was observed to have vaginal bruising. LALD-A confirmed she had investigated the cause of the bruising but did not file a vulnerable adult report as the hospital had already done so. On November 15, 2022, at 2:30 p.m. LALD-A stated she had talked with staff about R5's vaginal bruising after receiving the call from police. Staff indicated R5 was aggressive with wiping self after voiding to the point her skin would be red. LALD-A stated she called the hospital to let them know this and they were ok with it. LALD-A confirmed she had not documented this information anywhere, nor did she report the incident to MAARC. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated: 4. Reporting Maltreatment a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the licensed assisted living director (LALD) and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect, or financial exploitation, the LALD or designee will immediately make a report to MAARC ("Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD	0 620		

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0 620	Continued From page 17 or designee received initial knowledge that the incident occurred). b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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	0 650		

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0 650	Continued From page 18 (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two unlicensed personnel (ULP-E). 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-E had a hire date of February 9, 2021, and began providing direct care services for the licensee on August 1, 2021. ULP-E's record lacked an annual performance review. On November 14, 2022, at 3:12 p.m. the surveyor observed ULP-E don personal protective equipment prior to entering a resident's room.	0 650		

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0 650	Continued From page 19 On November 17, 2022, at 3:25 p.m. licensed assistant living director (LALD)-A stated she was unable to find evidence of an annual performance review for ULP-E. The licensee's Personnel Records policy revised July 29, 2021, indicated: 2. The personnel record for each person will include: h. Performance evaluations which identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 20 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 have a written emergency preparedness plan with all the required content. This had the potential to affect all current residents, staff, and any visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked an emergency preparedness and Appendix Z plan to manage the resident's care and services in response to a disaster or emergency. On November 14, 2022, at 10:30 a.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was requested. On November 16, 2022, at 3:52 p.m. licensed	0 680		

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0 680	Continued From page 21 assisted living director (LALD)-A stated she could not find the emergency preparedness book. LALD-A indicated a former employee had overseen the plan and might have taken the book with her when she ended employment two weeks prior. On November 17, 2022, at 11:55 a.m. LALD-A confirmed the emergency preparedness and Appendix Z plan book was missing. LALD-A verified the licensee lacked a customized emergency preparedness plan and Appendix Z to include all requirements. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z policy dated August 1, 2021, indicated the emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. The plan would be based on the assisted living based and community-based risk assessments, utilizing an all-hazards approach. No further information was 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; (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	0 730		

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0 730	Continued From page 22 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 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	0 730		

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0 730	Continued From page 23 Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4) with record reviewed. 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 began receiving services on July 7, 2022, and was discharged on September 24, 2022. R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R4's record included a form titled Discharge Summary - V2 dated September 25, 2022. The form included R4's date of admission and a notation R4 was stable upon discharge and moved back home with her boyfriend. On November 16, 2022, at 12:08 p.m. registered nurse (RN)-B stated what was documented on	0 730		

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0 730	Continued From page 24 R4's discharge summary lacked the required discharge summary content. RN-B indicated the form had not been filled out appropriately and a true summary had not been completed. The licensee's Resident Discharge Summary Form undated, noted the following is the resident's discharge summary: - a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review which includes the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed and over-the-counter medications -a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangement that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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	0 810		

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COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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
0 810	Continued From page 25 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 26 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On November 15 2022, from approximately 1:00 PM to 2:30 PM, survey staff requested fire safety training and evacuation plan documentation, but the licensee could not provide staff training and evacuation within the past year. Assisted Living Director (LALD)-A verbally confirmed survey staff observation during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced	0 970		

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0 970	Continued From page 27 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 19, section 29 of the contract indicated "As an occupant of the facility, resident assumes the risk for resident's own safety, and for the safety of resident's personal property, guests and agents. Resident will indemnify and hold harmless facility, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident or resident's guests of the apartment or any other part of facility, or caused wholly or in part of an act or omission of resident or resident's guest or agents." On November 16, 2022, at 12:37 p.m. licensed assisted living director (LALD)-A verified the	0 970		

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0 970	Continued From page 28 licensee's contract included the above content, and stated the same contract was utilized for all residents residing in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	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, 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; (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	01060		

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01060	Continued From page 29	01060		

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.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1).

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:

R1 was admitted to assisted living services on July 16, 2018.

R1's service plan undated, indicated R1 received the following services: medication administration, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming,

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01060	Continued From page 30 housekeeping, and laundry. R1's progress notes dated October 26, 2022, at 8:57 a.m. indicated R1 was unresponsive, twitching and staff had sent R1 to the emergency department. Progress notes dated November 7, 2022, at 10:18 a.m. indicated R1 had returned to the facility after his stay at the hospital. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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; - 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. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On November 16,2022, at 11:29 a.m. registered nurse (RN)-B verified there was no written notice provided to R1, nor had the ombudsman been notified of R1's emergency relocation. RN-B was unaware of requirement, indicating the licensee had not completed for any residents requiring hospitalization.	01060		

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01060	Continued From page 31 The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, included in the event of an emergency relocation, [the licensee] would provide a written notice that contains, at a minimum: - the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -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 return date is not currently known; - a statement that, if the facility refuses to provide housing or series after a relocation, the resident has the right to appeal. The facility will provide contact information for the agency to which the resident may submit an appeal. The notice required will be delivered as soon as practicable to: a. the resident, legal representative, and designated representative; b. for residents who receive home and community-based waiver services under the resident's case manager; and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01370	Continued From page 32	01370		
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; (14) procedures to use in handling various	01370		

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01370	Continued From page 33	01370		

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 was completed for one of two unlicensed personnel (ULP-E) to include all required content.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-E was hired on February 9, 2021, to provide direct care services to residents of the facility.

On November 14, 2022, at 3:12 p.m. ULP-E was observed donning personal protective equipment prior to entering a resident room.

ULP-E's employee record lacked documentation of training for the following topics:
- reports of changes in the resident's condition to the supervisor designated by the facility;
- maintenance of a clean and safe environment;
- training on the prevention of falls;
- medication, exercise, and treatment reminders;
- preparation of modified diets as ordered by a

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01370	Continued From page 34 licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family. On November 17, 2022, at 3:25 p.m., licensed assisted living director (LALD)-A confirmed being unable to locate evidence of the above trainings for ULP-E. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and	01380		

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01380	Continued From page 35 competency was completed for one of two unlicensed personnel (ULP-E) to include all required content with records reviewed. 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-E was hired on February 9, 2021, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of training for the following topics: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the client. On November 17, 2022, at 3:25 p.m. licensed assisted living director (LALD)-A confirmed being unable to locate evidence of the above trainings for ULP-E. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01610	Continued From page 36	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R3) prior to initiation of services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01610		

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01610	Continued From page 37 R3's diagnoses included Parkinson's disease and diabetes. R3's start of care date for services was June 27, 2022. R3's assisted living contract was signed by a legal representative on June 27, 2022. R3's admission assessment completed by the RN was dated June 28, 2022. The assessment was not completed prior to initiation of services on June 27, 2022. On November 16, 2022, at 11:51 a.m. RN-B confirmed she had not completed R3's admission assessment prior to the start of services. RN-B was unsure if a pre-admission assessment had been completed for R3. On November 17, 2022, at 3:22 p.m. RN stated being unable to locate evidence of a pre-admission assessment for R3. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated the facility will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		

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01620	Continued From page 38	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident 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 a reassessment not to exceed 90 days for two of three residents (R1, R3). In addition, the RN failed to complete a 14-day assessment timely for one of one resident (R3). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 39	01620		

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
R1's service plan undated, indicated R1 received the following services: medication administration, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry.

R1's last three assessments were requested. Assessments dated June 20, 2022, September 23, 2022, and November 8, 2022, were provided. The September 23, 2022, assessment was 95 days from the last date of the assessment, exceeding 90 calendar days.

On November 15, 2022, at 12:33 p.m. RN-B verified R1's assessment was greater than 90 days apart. RN-B stated if the due date falls on the weekend, they can complete it on the next business day even if it exceeds 90 days.

R3
R3's move-in date and start of services was June 27, 2022.

R3's service plan undated, indicated R3 received the following services: medication administration, ostomy management, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry.

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01620	Continued From page 40 R3's assessments were requested. R3's initial assessment was dated June 28, 2022, and his 14-day assessment was dated July 12, 2022 (15 days from R3's start of services). R3's quarterly assessment dated October 12, 2022, was 92 days from the previous assessment on July 12, 2022. On November 16, 2022, at approximately 2:00 p.m. RN-B verified R3's initial assessment was completed on June 28, 2022, one day after admission, making the 14-day assessment one day late. On November 17, 2022, at 2:04 p.m. RN-B further verified R3's quarterly assessment dated October 12, 2022, exceeded 90 days. The licensee's 6.01 Assessments, Review & Monitoring policy revised August 1, 2022, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service	01630		

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01630	Continued From page 41 plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to initiate a temporary service plan for one of one resident (R3) recently admitted to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Parkinson's disease and diabetes. R3's start of care date for services was June 27, 2022. R3's assisted living contract was signed by the resident's legal representative on June 27, 2022. R3's admission assessment completed by the registered nurse (RN) was completed on June 28, 2022. The assessment was not completed prior to initiation of services on June 27, 2022. R3's undated service plan, indicated a revision date of September 16, 2022. R3's record lacked evidence a temporary service plan was completed with the resident at the time	01630		

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01630	Continued From page 42 services were initiated by the facility as required. On November 17, 2022, at 3:22 p.m. RN-B she was unable to locate a temporary service plan for R3. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated: 10. Temporary Service Plans: a. If assisted living services are initiated for a new resident prior to the completion of a full individualized initial assessment, a temporary service plan is established. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated the facility will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01630		
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	01640		

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01640	Continued From page 43	01640		

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.
(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 a written service plan was revised to reflect the current services provided 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 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's prescriber orders dated November 7, 2022, included to follow up with urology (branch of medicine focuses on diseases of the urinary tract) to exchange urinary catheter (a tube for removing

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01640	Continued From page 44 urinary fluid) and talk about long term Foley (type of indwelling urinary catheter) plans. R1's hospital return assessment dated November 8, 2022, indicated R1 had a catheter which required staff assistance with catheter care. On November 15, 2022, at 12:15 p.m. unlicensed personnel (ULP)-H was observed providing catheter care for R1. On November 16, 2022, at 7:00 a.m. R1 was observed sitting at dining room table in wheelchair with catheter bag hanging on bottom of chair. R1's service plan undated, indicated R1 received the following services: medication administration, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry. The service plan failed to identify the treatment of catheter care assistance. On November 16, 2022, at 11:33 a.m. registered nurse (RN)-B confirmed R1's service plan failed to identify staff assistance with catheter care and should have been updated so the current services would be reflected on the service plan. The licensee's Contents of Service Plans policy dated July 28, 2021, indicated all assisted living residents would have an up-to-date service plan identifying services to be provided based on the assessment by the RN. Service plans will be reviewed and revised as needed based upon on-going resident assessments. No further information was provided.	01640		

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01640	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

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01650	Continued From page 46 the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan undated, indicated R1 received the following services: medication administration, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry R1's service plan lacked the following: - the frequency of each service R2's service plan dated April 16, 2021, indicated R2 received the following services: medication administration, assistance with TED stocking care, toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry. R2's service plan lacked the following: - the frequency of each service R3's service plan undated, indicated R3 received the following services: medication administration, ostomy care, assistance with toileting, transfers, mobility, bathing, dressing, hygiene/grooming, housekeeping, and laundry.	01650		

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01650	Continued From page 47 R3's service plan lacked the following: - the frequency of each service On November 17, 2022, at 2:04 p.m. registered nurse (RN)-B verified the content was lacking on the service plans and stated the same service plan format was utilized for all residents residing within the facility. The licensee's Contents of Service Plans policy dated July 28, 2021, noted the service plan would include frequency of each service according to resident assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700		

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01700	Continued From page 48 (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R2, R3, R11) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on November 14, 2022, at 10:30 a.m. licensed assisted living director (LALD)-A gave surveyors the current resident roster with services. LALD-A stated all current residents received medication	01700		

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01700	Continued From page 49 management services. R2 R2 was admitted on April 16, 2021, and began receiving assisted living services from the licensee on August 1, 2021. R2's diagnoses included diabetes and allergic rhinitis (a disorder caused by allergy-causing substance, called allergens. The common symptoms include sneezing, running nose). R2's Service Plan Agreement dated April 16, 2021, indicated R2 received services including medication administration. R2's prescriber orders dated October 17, 2022, included Lantus insulin 100 unit/ml (milliter), inject 20 units subcutaneously at bedtime, and a new order for fluticasone propionate 50 mcg/ACT (micrograms per actuation/spray) nasal suspension, use two sprays in each nostril daily. On November 15, 2022, at 11:30 a.m. R2 confirmed she received medication administration services including blood sugar checks and insulin. R2 stated the staff bring the insulin pen to her and she administered the insulin herself. On November 16, 2022, at 8:37 a.m. unlicensed personnel (ULP)-H was observed setting up R2's a.m. medications. ULP-H stated R2 kept her nasal spray in her room as the nurse said she could do that, though ULP-H had retrieved the nasal spray prior to administration so the surveyor could look at the label. Upon entering R2's room, ULP-H handed the fluticasone propionate nasal spray to R2 who stated she had already administered the spray earlier that morning.	01700		

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R2's Med Management Plan dated April 16, 2021, indicated: staff person will witness that all medications are taken.

R2's quarterly assessment dated November 2, 2022, indicated the resident was unable to self-administer medications.

On November 16, 2022, at 11:51 a.m. RN-B confirmed R2 had not been assessed to safely administer her own insulin or nasal spray.

R3
R3's move-in date and start of services was June 27, 2022.

R3's service plan undated, indicated R3 received services including medication administration.

R3's Medication Administration Record (MAR) dated June 2022, revealed staff had administered medication to R3 the evening of June 27, 2022.

R3's medication administration assessment dated June 28, 2022, was completed after initiation of medication administration services.

On November 16, 2022, at approximately 2:00 p.m. RN-B confirmed R3's medication management assessment should have been completed prior to receiving medication administration services.

R11
R11's diagnoses included severe stage bilateral glaucoma (eye disease resulting in vision loss and blindness) and mild cognitive impairment.

R11's prescriber orders dated October 27, 2022, included the following eye medications: one

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steroidal anti-inflammatory eye drop and three anti-glaucoma eye drops.

On November 15, 2022, at 3:17 p.m. the surveyor observed ULP-G have R11 self-administer the scheduled eye drop. ULP-G handed R11 the eye drops and R11 exclaimed "Oh you want me to do it?" ULP-G verbally encouraged R11 that she could do it and told her the instructions for the eye drop (one drop to left eye). ULP-G stated there was no instruction on medication administration record (MAR) for R11 to self-administer her eye drops, but indicated he "knows her" and she was capable of doing it herself.

R11's record included a medication management plan dated May 30, 2022. The plan identified medication administration would be provided by facility staff.

R11's record included a 14-day assessment dated September 22, 2022. The assessment did not identify R11 would self-administer any medications themselves.

On November 16, 2022, at 11:53 a.m. registered nurse (RN) stated a self-administer order would be noted in the medication administration record and be on the task list for staff to reference.

On November 16, 2022, at approximately 2:00 p.m. RN-B confirmed there was no assessment or order for R11 to self-administer her eye drops.

The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified prior to providing medication management services, a registered nurse, licensed health professional, or authorized

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01700	Continued From page 52 prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for two of five residents (R8, R1) observed during medication administration. 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	01760		

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COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R8's diagnoses included asthma (a lung disorder characterized by narrowing of the airways) and cataract (a condition affecting the eye that causes clouding of the lens).

R8's undated, Service Plan Agreement identified services included medication administration.

R8's physician orders dated April 28, 2022, included dorzolamide 2% (treats increased eye pressure) ophthalmic solution, administer one drop into the right eye two times a day, brimonidine 0.2% (treats increased eye pressure) ophthalmic solution, administer one drop into the right eye two times a day, Spiriva (relaxes and opens the airways) with Handihaler 18 microgram (mcg) inhalation, inhale one capsule (18 mcg total) daily, and Advair (relaxes and opens the airways) HFA (Hydrofluoroalkane, which is the propellant in the inhaler) 230-21 mcg/actuation inhaler. Inhale two puffs by mouth twice daily. Rinse mouth with water after use. Do not swallow.

On November 16, 2022, at 7:24 a.m. unlicensed personnel (ULP)-H was observed setting up R8's inhalers and dorzolamide eye drop. ULP-H stated she administered these medications to R8 first as she needed to wait three minutes between her two eye drops. ULP-H entered R8's room and handed the resident her Spriva inhaler and instructed her to inhale. ULP-H then handed the

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resident her Advair HFA inhaler and instructed her to inhale two puffs. ULP-H then administered R8's dorzolamide eye drops into the resident's right eye. ULP-H then informed R8 she would return after setting up her pills. ULP-H did not offer or instruct R8 to rinse her mouth following administration of the Advair HFA inhaler. At 7:30 a.m., surveyor observed ULP-H set up R8's oral medications and brimonidine eye drops. ULP-H entered R8's room and handed R8 the medication cup with her oral pills; R8 took them independently. ULP-H again did not offer/instruct R8 to rinse her mouth prior to taking her oral medications.

On November 16, 2022, at 7:45 a.m. ULP-H confirmed she had not instructed R8 to rinse her mouth following administration of the Advair inhaler. ULP-H stated the resident gets water afterwards when she takes her medications, though she does swallow it rather than rinsing and spitting.

R1 Medication Error

R1's service plan undated, identified services included medication administration.

R1's prescriber's orders dated November 7, 2022, included empagliflozin (for diabetes) 10 milligrams (mg) by mouth one time a day. The orders did not include Lasix (for excess fluid) or vitamin D (supplement).

On November 16, 2022, at 7:20 a.m. the surveyor observed ULP-G prepare R1's morning medications. ULP-G obtained R1's empagliflozin medication bottle from the medication cart and after comparing the label with R1's medication administration record (MAR), proceeded to place a pre-cut 1/2 tablet in the medication cup from the bottle. R1's empagliflozin medication bottle label

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was examined by the surveyor which included the residents' name; however, the label stated 25 mg take 1/2 tab (12.5 mg) daily. When interviewed at this time ULP-G stated, "this is what we give him" and proceeded to administer the medication to R1 including Lasix 20 mg daily by mouth and vitamin D 125 micrograms (mcg) by mouth daily.

On November 16, 2022, at 11:18 a.m. RN-B verified R1's medication bottle dosage did not match R1's medication order. RN-B stated this would be a medication error and would need to get order clarified.

On November 17, 2022, at 11:27 a.m. RN-B verified R1's prescriber orders did not include Lasix or Vitamin D and both medications should have been discontinued during reconciliation of orders. RN-B stated there used to be a second nurse to double check the orders processed during reconciliation, but she ended employment a few weeks prior and did not have a second check of these orders.

R1 Lack of Documentation why Medications not Administered
R1's prescriber orders dated September 19, 2022, included the following medications:
-atorvastatin calcium (for cholesterol) 80 mg by mouth one time a day
-carvedilol (for blood pressure) 6.25 mg by mouth two times a day
-Coumadin (blood thinner) 4 mg by mouth one time a day
-empagliflozin (for diabetes) 10 mg by mouth one time per day
-Ensure (nutritional supplement) 1 can by mouth one time a day
-hydrocortisone (steroid cream) 2.5 % apply to facial rash topically one time a day

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-ipratropium bromide (for runny nose) solution 1 spray in both nostrils three times a day
-isosorbide mononitrate (prevents chest pain) extended release (ER) 24-hour 30 mg by mouth one time a day
-Lasix (for excess fluid) 20 mg by mouth one time a day
-lorsartan potassium (for blood pressure) 25 mg by mouth one time a day
-melatonin (supplement for sleep) 3 mg by mouth one time a day
-miconazole nitrate (antifungal) 2 % apply to red areas topically two times a day
-multiple vitamin (supplement) by mouth one time a day
-tamsulosin hydrochloride (for prostate) 0.4 mg by mouth one time a day
-Vitamin D (supplement) 125 mcg by mouth one time a day

Review of R1's MAR dated November 1, 2022, through November 14, 2022, indicated R1's record lacked documentation of administered medications for the following dates:
atorvastatin calcium
- 8:00 p.m. dose November 2, 2022, and
- 8:00 p.m. dose November 6, 2022

carvedilol
- 4:30 p.m. dose November 2, 2022,
- 4:30 p.m. dose November 6, 2022, and
- 8:00 a.m. dose November 7, 2022

Coumadin
- 8:00 p.m. dose November 2, 2022, and
- 8:00 p.m. dose November 6, 2022

empagliflozin
- 8:00 a.m. dose November 7, 2022

Ensure
- 8:00 a.m. dose November 7, 2022

hydrocortisone cream
-7:30 a.m. dose November 7, 2022

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ipratropium bromide
- 2:00 p.m. dose November 2, 2022,
- 8:00 p.m. dose November 2, 2022,
- 8:00 p.m. dose November 6, 2022, and
- 8:00 a.m. dose November 7, 2022

isosorbide mononitrate ER
-8:00 a.m. dose November 7, 2022

Lasix
-8:00 a.m. dose November 7, 2022

lorsartan potassium
-8:00 a.m. dose November 7, 2022

melatonin
-8:00 p.m. dose November 2, 2022, and
-8:00 p.m. dose November 6, 2022

miconazole nitrate
-8:00 p.m. dose November 2, 2022,
-8:00 p.m. dose November 6, 2022, and
-8:00 a.m. dose November 7, 2022

multiple vitamin
- 8:00 a.m. dose November 7, 2022

tamsulosin hydrochloride
- 8:00 a.m. dose November 7, 2022

vitamin D
- 8:00 a.m. dose November 7, 2022

On November 16, 2022, at 11:48 a.m. RN-B verified R1's MAR lacked documentation of administered medications for the above listed dates. RN-B stated her expectation is staff would chart why a medication is not given. RN-B added R1 was in the hospital October 26, 2022, through November 7, 2022, but staff should have had alternative documentation of why the medications were not given.

The licensee's 7.35 Inhaler policy dated August 1, 2022, indicated 11. Provide resident the opportunity to rinse out mouth.

The licensee's Medication Errors policy reviewed

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01760	Continued From page 58 June 24, 2021, identified a medication error included but was not limited to when: an incorrect dosage is given, a medication is skipped or given at the wrong time, or a medication is given to a client that is not consistent with the prescription. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 28, 2021, included medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment, or therapy c. Right time d. Right route e. Right dose f. Right chart/record to document that the medication, treatment, and therapy was taken. The licensee's Requesting and Receiving Medication Prescriptions and Refills policy reviewed July 28, 2021, noted the nurse is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, to be managed by our staff are kept in the resident's record and that changes in orders are addressed in the resident's MAR, and are communicated on a timely basis to all appropriate staff. The nurse will make any changes to the MAR immediately after receiving a prescription for a change in medication or a new medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01770	Continued From page 59	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on November 14, 2022, at 10:30 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents, including medication setup for residents on coumadin (blood thinner). R1's service plan undated, indicated R1 received the service of medication administration, R1's prescriber orders dated November 7, 2022, included the following order: warfarin (blood thinner) 4 milligrams (mg) by mouth daily.	01770		

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01770	Continued From page 60 On November 15, 2022, at 2:52 p.m. the memory care medication cart was observed with unlicensed personnel (ULP)-G. In the top drawer was a yellow mediminder (medication dispenser) box labeled "Coumadin" (blood thinner) with R1's name on it. ULP-G stated the mediminder contained R1's scheduled coumadin set up by the nurse. R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On November 16, 2022, at 12:04 p.m. registered nurse (RN)-B stated she did not document that a medication setup had been completed, or what medications, quantity of dose, times, or route. RN-B further stated this was the process used for all medication set ups and was not aware of this requirement. The licensee's 7.08 Medication Management - Administration & Setup policy dated August 1, 2021, noted a licensed nurse would correctly and accurately document any medication setup provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01890 SS=D	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	01890		

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01890	Continued From page 61 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 time sensitive medications were dated when opened for one of one resident (R11) with eye drops. In addition, the licensee failed to ensure medications were maintained bearing the original label for one of one resident (R1) with nasal spray. 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: On November 15, 2022, at 2:52 p.m. the surveyor observed the medication cart on the memory care unit with unlicensed personnel (ULP)-G. R11's Xalatan (anti-glaucoma) 0.005% eye drops lacked a date to indicate when staff opened it, or when it would expire. R11's Azopt (anti-glaucoma) 1% eye drops lacked a date to indicate when staff opened it, or when it would expire. R11's prednisolone acetate (steroidal anti-inflammatory) 1% eye drops lacked a date to	01890		

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01890	Continued From page 62 indicate when staff opened it, or when it would expire. R11's timolol maleate (anti-glaucoma) 0.5 % eye drops had a date open sticker on the bottle; however, the date was illegible. The eye drop lacked a date to indicate when it would expire. R1's ipratropium bromide (for seasonal allergies) 0.06% nasal spray lacked a prescription label to include the residents name, dosage, or instruction on how to take the medicine. ULP-G confirmed the findings and indicated he was not aware eye drops should be dated when opened and when they would expire. ULP-G further confirmed R1's nasal spray lacked a label, but stated the medication was R1's because it was in R1's medication compartment of the medication cart. On November 16, 2022, at 11:18 a.m. registered nurse (RN)-B confirmed all eye drops should be dated when opened. RN-B further stated the nasal spray should have had a label on the medication. The Xalatan package insert revised August 2011, noted: -once a bottle is opened for use, it may be stored at room temperature for six weeks. The Azopt package leaflet information for the user revised June 2018, instructed: -you must throw away a bottle four weeks after you first opened it, to prevent infections. Write down the date you opened on the bottle label and box. The prednisolone acetate package leaflet	01890		

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01890	Continued From page 63 information for the user revised February 2022, noted: -discard the bottle 28 days after opening, even if there is solution remaining. The licensee's Storage of Medication policy revised July 28, 2021, noted the medication must include the expiration date of time-dated drugs. The licensee's 7.13 Medications - Prescription Drugs & Prohibition policy dated August 1, 2021, identified when [The Licensee] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system	02040		

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02040	Continued From page 64 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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 the potential to affect a large portion or all residents. The findings include: On November 15 2022, from approximately 1:00 PM to 2:30 PM, survey staff toured the facility with (LALD)-A . During the facility tour, survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is	02070		

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physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the facility was staffed 24 hours a day, seven days a week in the locked memory care unit. This had the potential to affect all residents residing at the facility and resulted in an immediate correction order on November 14, 2022, at 1:31 p.m.

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

The findings include:

The facility was licensed as an assisted living facility with dementia care.

On November 14, 2022, at 10:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A, identified there were two staff working during the night shift, one for the secured memory care unit and one for the assisted living.

On November 14, 2022, at 11:51 a.m. during the facility tour, LALD-A stated staff have left the

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COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

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02070	Continued From page 66	02070		

secured memory care unit at night to assist staff in the assisted living with transfers.

On November 14, 2022, at 1:10 p.m. unlicensed personnel (ULP)-C stated he had not worked night shift for about a year, but would leave the secured memory care unit at night to assist the staff member in the assisted living part, if needed.

On November 14, 2022, at 1:15 p.m. ULP-D stated she worked the night shift when needed for split shifts. ULP-D stated there was a resident on the assisted living side that was a two person assist. ULP-D further stated she has left the memory care unit to help on the assisted living side during the night, leaving the locked memory care unattended. ULP-D stated "it's usually only for a couple of minutes."

On November 14, 2022, at 1:18 p.m. registered nurse (RN)-B stated night staff would leave the locked memory care unit unattended to assist on the assisted living side if needed. RN-B further indicated she was aware staff could not leave the secured memory unit but had "never thought about it before," and further indicated there would have to be some changes made in the scheduling.

The daily staffing schedule from November 6, 2022, through November 19, 2022, was reviewed. Only two staff were scheduled for the night shift.

The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy undated, identified a minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two.

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02070	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 15, 2022, the immediacy of correction order 2070 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) Days	02070		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented;	02110		

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02110	Continued From page 68 (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the	02110		

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02110	Continued From page 69 time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On November 16, 2022, at 12:10 p.m. registered nurse (RN)-B confirmed residents and/or their designated representatives had not been provided with written dementia care policies and procedures at time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02170	Continued From page 70	02170		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of three residents (R1 and R2) who resided in the assisted living with dementia care facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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:

The licensee held an assisted living with dementia care (ALDC) license, effective August 1, 2022. The facility was licensed for a capacity of 37 residents and had a current total census of 24 residents (five residents living within the dementia care unit.

R1
R1's diagnoses included cognitive impairment and altered mental status.

R1's Community Life Initial/Life Story Assessment form undated, noted the resident's past and current interests, emotional and social needs and patterns. R1's record lacked an evaluation of the following:
- current abilities and skills;

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02170	Continued From page 72 - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnosis included kidney failure. R2's Resident Profile/History form dated February 3, 2021, noted the resident's past and current interests, current abilities and skills, and identification of actives for behavioral interventions. R2's record lacked an evaluation of the following: - emotional and social needs and patterns; - physical abilities and limitations; and - adaptations necessary for the resident to participate. In addition, R2's record lacked the development of an individualized activity plan. On November 16, 2022, at 9:21 a.m. life enrichment coordinator (LEC)-I stated R1 and R2's record lacked the above required content. LEC-I stated there are different activity evaluations because the licensee kept changing and updating the forms. LEC-I was not aware of the activity evaluation components or plan requirement. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC policy dated October 26, 2021, noted each resident must be evaluated for activities to	02170		

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02170	Continued From page 73 include past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, and identification of activities for behavioral interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R2) with a bed rail. This resulted in an immediate correction order on November 16, 2022, at 12:30 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	02310		

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situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On November 16, 2022, at 8:37 a.m. the surveyor observed unlicensed personnel (ULP)-H administer medications to R2 in her room. During administration, the surveyor observed a U-shaped bed rail on the resident's bed. After R2 was finished taking the medication, the surveyor asked if she could check out the bed rail to make sure it was secure. R2 stated that was ok and that the rail was bolted to the bed frame as is was an electric bed and couldn't just be put under the mattress. R2 stated she utilized the rail to assist with getting in and out of bed.

R2's diagnoses included acute kidney failure with tubular necrosis (kidney disorder involving damage to the tubule cells of the kidneys, which can lead to acute kidney failure), diabetes, and muscle weakness.

R2's Service Plan dated April 16, 2021, indicated R2 received services including medication administration, thromboembolism-deterrent (TED) hose (support stockings to prevent blood clots) application and removal, bathing, laundry, and housekeeping.

R2's quarterly assessment dated November 2, 2022, identified R2 was independent with ambulation, transfers, toileting, and bed mobility. The assessment did not include the use of a bed rail.

R2's Bed Assist Device Assessment dated November 14, 2022, indicated R2 was alert and oriented x (times) three. The assessment also

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read: "Is the bed rail part of a hospital bed system or does the manufacturer instruction require zone measurements," with a response of "No, zone measurements not required." The resident's bed rail was not part of a hospital bed system or did the manufacturer's instructions require zone measurements. The assessment indicated, "NA" (not applicable) for the name of the manufacturer or the bed assist device and also indicated the device was not listed as being recalled. The remainder of the assessment was incomplete.

On November 16, 2022, at 12:30 p.m. registered nurse (RN)-B confirmed she had not assessed R2's bed rail until November 14, 2022, when surveyors requested the documentation. RN-B stated she did a walk through in the building on November 14, 2022, to see which residents had bed rails. RN-B did not know how long the resident had the bedrail and confirmed she did not have manufacturer's instructions and had not fully completed the assessment.

On November 16, 2022, at 1:00 p.m. R2 stated she obtained her consumer purchased bedrail approximately six weeks after moving into the assisted living facility in April 2021, and further confirmed the maintenance man installed it on her bed. R2 confirmed licensed assistant living director (LALD)-A brought the Negotiated Risk Agreement form outlining the possible risks of the bed rail to her this week to sign. R2's Negotiated Risk Agreement was signed by the resident and LALD-A on November 14, 2022.

R9
On November 16, 2022, at 2:45 p.m. R9 was observed lying in a hospital bed with bilateral full rails. R9 stated her sister had purchased the bed and R9 had used it since admitting to the assisted

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living facility. The bilateral bed rails had three long metal rails that extended the length of the bed leaving two open linear spaces between the rails that measured approximately three and a half inches between the rails.

R9's diagnoses included, injury of cervical spinal cord, chronic pain syndrome, major depressive disorder and anxiety.

R9's Service Plan dated March 15, 2021, indicated R9 received services including assistance with all activities of daily living including bathing, laundry, and housekeeping.

R9's quarterly assessment dated October 6, 2022, identified R9 required assistance from staff with dressing, grooming, bathing, personal hygiene, and transfers. The assessment did not include the use of a bed rail.

R10
R10's diagnoses included congestive heart failure and weakness.

R10's undated, Service Plan indicated R10 received services including assistance medication administration, ostomy management, laundry and housekeeping.

R10's Bed Assist Device dated November 14, 2022, indicated the risks/benefits of the side rail was not discussed with the resident or resident representative nor was FDA (United States Food and Drug Administration) bedrail guidance provided.

On November 16, 2022, at approximately 2:40 p.m. RN-B confirmed the assessment had not been completed for R9's bed rails and further

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02310	Continued From page 77 confirmed R10's bed rail assessment was completed on November 14, 2022, after the surveyors requested the bed rail assessments. The licensee's 6.29 Side Rails policy dated August 1, 2021, noted when a resident is utilizing side rails on a bed, [The Licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 17, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of H. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	03000		

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03000	Continued From page 78 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the	03000		

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licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R5).

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

The findings include:

R5's diagnoses included Alzheimer's disease and major depressive disorder.

R5's Vulnerability Safety Risk assessment dated August 23, 2022, indicated the resident was inconsistent with reporting issues due to forgetfulness. Staff to provide reminders and cuing, and also monitor for any signs of abuse.

During the entrance conference on November 14, 2022, at 10:30 a.m. licensed assistant living director (LALD)-A indicated R5 had been taken to the hospital last evening due to a fall and subsequently was diagnosed with a urinary tract infection. LALD-A stated the police called the facility because hospital staff had notified them that R5 was observed to have vaginal bruising. LALD-A confirmed she had investigated the cause of the bruising but did not file a vulnerable adult report as the hospital had already done so.

On November 15, 2022, at 2:30 p.m. LALD-A stated she had talked with staff about R5's

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	30477	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT RESIDENCE LESUEUR	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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
03000	Continued From page 80	03000		

vaginal bruising after receiving the call from police. Staff indicated R5 was aggressive with wiping self after voiding to the point her skin would be red. LALD-A stated she called the hospital to let them know this and they were ok with it. LALD-A confirmed she had not documented this information anywhere, nor did she report the incident to MAARC.

The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated:
4. Reporting Maltreatment
a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the licensed assisted living director (LALD) and that person will complete an incident report.
a. If the incident appears to be suspected abuse, neglect, or financial exploitation, the LALD or designee will immediately make a report to MAARC ("Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the incident occurred).
b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately.
c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

DEPARTMENT OF HEALTH

Type: Full
Date: *11/14/22*
Time: 11:00:00
Report: 1033221187

Food and Beverage Establishment Inspection Report

Location:
Comfort Residence Lesueur
105 Plum Run Road
Le Sueur, MN56058
Le Sueur County, 40

Establishment Info:
ID #: 0037531
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633771800
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.

Quaternary ammonium test kit is expired.

Comply By: 11/28/22

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Can opener blade has visible dried food debris on it.

Comply By: 11/14/22

4-200 Equipment Design and Construction

4-201.11AMN

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

Facility is using residential crock pots.

Comply By: 11/14/22

Food and Beverage Establishment Inspection Report

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

There is no hand wash sign in the rest rooms used by employees.

Comply By: 11/21/22

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Shepards Pie-Cooler
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: Beef Stroganoff-Hot Line
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Snack Cooler
Violation Issued: No

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

Type: Full
Date: *11/14/22*
Time: 11:00:00
Report: 1033221187
Comfort Residence Lesueur

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033221187 of 11/14/22.

Certified Food Protection Manager: Alisa B Beneke

Certification Number: FM85127 Expires: 07/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Alisa B Beneke

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us