Electronically Delivered

March 12, 2025

Licensee
Home And Comfort, Inc. Of Grand Rapids, Mn
500 Powell Avenue
Coleraine, MN 55722

RE: Project Number(s) SL30761016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

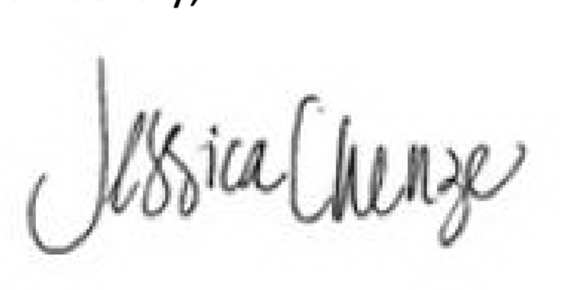
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30761	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

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0 000	Initial Comments 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: SL30761016 On February 10, 2025, through February 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 14 residents; all of whom were receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 had an Assisted Living license effective November 1, 2024. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "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	0 420		

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "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." Page six was electronically signed by the owner/authorized agent on August 14, 2024. As a result of this survey, the following orders were issued under 0510, 0650, 0660, 0775, 0780, 0800, 0810, 1060, 1420, 1500, 1530, 1560, 1640, 1750, 1760, 1880, 1890, 1940, 1950, 1960, 1970, 2310, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 3 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reusable equipment was cleaned in-between resident use, by one of two employees (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure infection control standards were followed by one of two employees (ULP-B) while providing medication and treatment 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: HOYER LIFT (mechanical lift/device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers, sling type). On February 10, 2025, at 1:04 p.m., the surveyor	0 510		

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0 510	Continued From page 4 observed ULP-D obtain a Hoyer lift from R7's room and take the Hoyer lift to R6's room. ULP-B and ULP-D used the Hoyer lift to transfer R6 from R6's electric wheelchair into R6's hospital bed using correct technique. After ULP-D and ULP-B provided personal care to R6, ULP-D moved the Hoyer lift to an area in the dining area to "get it (Hoyer) charged up." The surveyor did not observe the Hoyer lift get sanitized before or after R6's use. Directly after the above observation, ULP-D stated the Hoyer was cleaned at the beginning and at the end of the shift, not in-between resident use. ULP-D added "I don't think we ever have cleaned it (Hoyer) more often, maybe during COVID." On February 10, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A stated equipment such as the Hoyer lift, should be cleaned in-between residents. LALD-A and CNS-C stated the housekeeper cleans the Hoyer in the morning and evening also. LALD-A stated the housekeeper used to have cleaning wipes for the Hoyer. LALD-A stated ULP-D thought the Hoyer had been cleaned in-between resident's due to COVID. RESIDENT ASSIST On February 11, 2025, at 8:11 a.m., the surveyor observed ULP-B take a medication cup of oral medications, an inhaler, a bottle of nasal spray and a glass of water to R4's room. ULP-B administered R4's medication. ULP-B removed a finger poke blood glucose (BG) system from a pouch. ULP-B cleaned R4's pointer finger of left hand and used a lancet (small needle used to poke the skin [usually on a finger] to get a small	0 510		

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0 510	Continued From page 5 drop of blood). The blood sample was put onto a BG testing strip which had been inserted into the BG meter (device that will test blood sample to determine BG level) to obtain a reading of 146. ULP-B left R4's room wearing gloves. ULP-B took the glass to the kitchen. ULP-B returned to the medication preparation area, removed the test strip from the BG meter, placed a tip on the end of the lancet and returned the BG testing supplies into the pouch. ULP-B removed one glove and unlocked the medication cart. ULP-B returned the inhaler and the nasal spray back into R4's medication drawer and locked the cart. On February 11, 2025, at 8:18 a.m., ULP-B removed the other glove. The surveyor observed ULP-B document R4's medication as administered. ULP-B removed R11's medication from the medication cart. The surveyor did not observe ULP-B perform hand hygiene after R4's medication administration or BG monitoring and prior to collecting R11's medication. Directly after the above observation, ULP-B stated she usually performed hand hygiene after she removed her gloves. ULP-B commented, "oh yeah, I did remove my gloves here. I normally removed them (gloves) out there (kitchen area) and use sanitizer." ULP-B added she (ULP-B) usually made her own hand sanitizer. On February 11, 2025, at 8:24 a.m., ULP-B looked for sanitizer at the medication preparation area and stated, "there is not even sanitizer here" (medication preparation area). On February 11, 2025, at 9:09 a.m., CNS-C stated hands should be washed after BG monitoring, and after glove removal. CNS-C said hand sanitizer should be used after resident	0 510		

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0 510	Continued From page 6 assist. The licensee's Cleaning of Shared Medical Equipment policy dated November 30, 2021, noted the licensee would implement and maintain processes to ensure all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reuse. Common shared resident care equipment may include mechanical lifts: - all equipment must be cleaned immediately if visibly soiled, and immediately after use of residents with contact precautions, regardless of cleaning schedule-items routinely shared, which cannot be cleansed between uses, will follow a regular schedule for cleaning and disinfection - cleaning and maintenance processes would follow manufacturer's recommendations - in the absence of recommendations, clean non-critical medical equipment surfaces with a mild detergent followed by cleaning with a disinfectant. The licensee's Gloves policy dated November 30, 2019, noted gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed: - wash hands - apply gloves to both hands - removed contaminated materials - place materials in proper receptacle - removed gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out - dispose used gloves in proper receptacle - rewash hands. The licensee's Standard Precautions policy dated November 30, 2021, noted standard precautions	0 510		

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0 510	Continued From page 7 apply to exposure to: -blood -all body fluids, secretions, and excretions, except sweat, regardless of whether or not they contain visible blood. Standard precaution includes the use of: -hand washing -appropriate personal protective equipment such as gloves, gowns, masks, whenever touching or exposure to patient's body fluids is anticipated -hands should be washed after removing gloves and after any direct contact with body secretions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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0 650	Continued From page 8 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained required content for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 February 10, 2025, at 9:42 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee offered and provided modified diets. ULP-D was hired on June 9, 2011, to provide direct care services to the licensee's residents. ULP-D's record did not include training and competency for modified diets. On February 11, 2025, at 11:48 a.m., LALD-A stated modified diet training and competency was	0 650		

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0 650	Continued From page 9 not in ULP-D's record. On February 11, 2025, at 12:07 p.m., CNS-C stated she was sure most of the staff were trained for modified diets. CNS-C stated occupational therapy (OT) came to the facility and trained and deemed the ULPs competent when R7 received a modified diet. CNS-C stated she also trained ULPs and felt the ULPs were competent with modified diets. CNS-C and LALD-A stated they were not able to find of modified diet training in ULP-D's record. CNS-C and LALD-A stated some of the ULPs records would include modified diet training. The licensee's Orientation & Training Records policy dated December 14, 2021, noted the licensee would document the following information for each competency evaluation, training, retraining, and orientation: - name of the training topic or training program - the training methodology, such as classroom style, web-based training, video, or one-to-one training - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff personal successfully completed the training as described in the training documenting - documentation of the completed competency	0 650		

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0 650	Continued From page 10 evaluation, training, retraining, or orientation would be provided to the employee at the time the evaluation or training was completed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 11	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by not completing a TB risk assessment annually. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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	30761	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

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0 660	Continued From page 12 During the entrance conference on February 10, 2025, at 10:01 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated they recently completed annual TB screening for staff. LALD-A added the staff screening just got completed last month. LALD-A stated they (licensee) "flipped it," by completing yearly (annual) staff screenings, rather than updating the TB risk assessment annually. On February 10, 2025, at approximately 11:00 a.m., the surveyor reviewed the facility's TB risk assessment: -date last TB risk assessment was conducted: April 25, 2022. On February 10, 2025, at approximately 11:15 a.m., LALD-A and CNS-C stated the licensee had not completed an annual TB risk assessment as required. The licensee's Tuberculosis Screening policy dated November 30, 2021, noted the facility would maintain a current community TB risk assessment. The assessment would be updated annually, using the data and form provided by the Minnesota Department of Health. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 of the residents). Findings include: On a facility tour on February 13, 2025, from 11:00 a.m. to 12:30 p.m., with licensed assisted living director/ owner (LALD/O)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: The dehumidifiers in the crawl space were powered by extension cords and not plugged directly into a power outlet. Electrical appliances are required to be plugged directly into a power outlet or over current protected power strip. There was an electrical wire rolled up with	0 775		

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0 775	Continued From page 14 exposed electrical wires near the sump pump in the crawl space. Exposed electrical wires are required to be spliced inside an approved electrical box in accordance with MSFC in Minnesota Rules Chapter 7511 and Minnesota Electrical Code in Minnesota Rules Chapter 1322. The exterior exit path was not maintained clear of snow to the required unlocked gate on the north end of the exterior fenced area and leading occupants to the public way. The exterior exit path is required to be maintained free of obstructions that prevent full and immediate use in the event of a fire or similar emergency. During the facility tour LALD-O-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 15 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms, interconnected smoke alarms, and maintain existing hardwired smoke alarms throughout the facility. 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 of the residents). Findings include: INTERCONNECTION On a facility tour on February 13, 2025, from 11:00 a.m. to 12:30 p.m., with licensed assisted living director/ owner (LALD/O)-A, it was observed that smoke alarms were not interconnected so activation of one alarm	0 780		

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0 780	Continued From page 16 activates all alarms throughout the facility. During the tour LALD/O-A, activated a test button on the smoke alarms at it was observed the smoke alarm inside resident sleeping room 24 was not interconnected to sound with all other smoke alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD/O-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. OUTSIDE OF SLEEPING ROOMS On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of resident sleeping room nine. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms. During the tour LALD/O-A, verified smoke alarms were not installed outside in the immediate vicinity of resident room nine. SMOKE ALARM POWER SOURCE It was observed the existing hardwired smoke alarms (receiving power from the building electrical system) were removed and replaced with battery power only interconnected smoke alarms. During the tour on February 13, 2025, from 11:00	0 780		

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0 780	Continued From page 17 a.m. to 12:30 p.m., LALD/O-A, stated the hardwired alarms were removed and replaced with battery power only alarms in order to provide interconnected alarms. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 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	0 800		

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0 800	Continued From page 18 pervasive). Findings include: On a facility tour on February 13, 2025, from 11:00 a.m. to 12:30 p.m., with licensed assisted living director/ owner (LALD/O)-A, the surveyor made the following observations of facility disrepair: The bathroom exhaust fans in the bathroom of resident sleeping rooms three and four and the employee bathroom did not operate when the wall switch was turned on. Bathroom exhaust fans are required to be maintained in operating condition in order to provide exhaust air from the bathroom. During the facility tour LALD/O-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=C	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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,	0 810		

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0 810	Continued From page 19 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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 develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 810		

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0 810	Continued From page 20 The findings include: On February 13, 2025, at 10:10 a.m., LALD/O-A, with licensed assisted living director/ owner (LALD/O)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated May 16, 2025, failed to include the following: The FSEP did not identify specific fire protection actions for residents, evident by not providing procedures for residents to take in the event of a fire or similar emergency in writing in the FSEP. During an interview on February 13, 2025, at 10:20 a.m., LALD/O-A, stated resident procedures to take in the event of a fire or similar emergency were not available in writing in the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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:	01060		

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01060	Continued From page 21 (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative;	01060		

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01060	Continued From page 22 and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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 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: R5's diagnoses included major depressive disorder, heart disease, unspecified, hypertension (HTN/high blood pressure), obesity, emphysema (air sacs in the lungs become damaged and stretched), and anxiety disorder. R5's service plan dated March 27, 2024, indicated R5 received the following services: ambulation assist, bathing assist, compression stockings (TEDS), denture care, grooming, exercise, oxygen delivery, vital sign monitoring, skin care, toileting, transfer assistance, and housekeeping services. R5's resident notes included: - dated December 12, 2024, resident was admitted to the hospital with pneumonia and a UTI (urinary tract infection.) - dated December 26, 2024, resident was discharged from the hospital on December 23, 2024, at 12:30 p.m., and admitted to (name of long-term care/LTC). She will be there for short	01060		

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01060	Continued From page 23 term rehab and return to us once she is done. - dated January 10, 2025, Resident returned from the LTC at 1:50 p.m., physical and occupational therapy (PT/OT) here now. R5's record lacked a written notice that contained, at a minimum: - notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days - if known and applicable, the approximate date or range of dates within which the resident was 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. On February 10, 2025, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated R5 had been out for a month, and she did not notify the OOLTC. CNS-C stated she was not aware of the requirement. CNS-C said she updated family, case workers, and doctors of R5's absence. The licensee's Emergency Relocation policy dated November 8, 2022, noted: - 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 nay service provider - contact information for the Office of Ombudsman and Long 0-Term Care - if known and applicable, the approximate date	01060		

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01060	Continued From page 24 or range of dates within which the resident is expected to return to the facility, or a statement that a return date was not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident had the right to appeal - the facility would 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 - the resident, legal representative, and designated representative - for resident who received home and community-based waiver services, the resident's case manager, and - the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility with four days No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel	01420		

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01420	Continued From page 25 must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for delegated tasks provided by unlicensed personnel (ULP) for three of three residents (R6, R5, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R6 R6's diagnoses included multiple sclerosis (MS/chronic autoimmune disease that affects the central nervous system (brain and spinal cord). R6's service plan dated August 23, 2024, indicated R6 received the following services: temperature daily, and catheter (catheter is a tube placed in the body to drain and collect urine from the bladder) care twice daily. R6's master care plan dated December 5, 2024, noted: genitourinary system (urogenital	01420		

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	30761	A. BUILDING: _____ B. WING _____	02/13/2025

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01420	Continued From page 26 system/urinary and reproductive) system: -needs help with catheter care- Foley (type of catheter) -history of urinary tract infections (UTI)-gets frequent UTIs. On February 10, 2025, at 1:04 p.m., the surveyor observed ULP-B and ULP-D transfer R6 from an electric wheelchair into a hospital bed. ULP-D and ULP-B checked R6's brief. ULP-D checked R6's catheter leg bag and commented, "it (bag) does not need to be dumped yet (emptied)". CATHETER R6's Rtask (computer system used) service record, active October 23, 2024, noted, for catheter care: -provide routine catheter care including hygiene, changing and cleansing drainage bags, reporting observations to the nurse. Complete with a.m. (morning) and HS (hour of sleep) cares and as needed (PRN). TEMPERATURE R6's Rtask service record, active October 23, 2024, noted, record temperature: -monitor and record temperature. Notified nurse (specify): - blank. On February 10, 2025, at 4:28 p.m., clinical nurse supervisor (CNS)-C stated she "forgets" she works with ULPs and not other nurses. CNS-C stated she forgot to include specific information in resident records, such as when and what to report to nursing. CNS-C stated R6's record should include what to report for catheter issues/concerns and that vinegar was used to clean R6's catheter. On February 10, 2025, at 4:31 p.m., CNS-C	01420		

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01420	Continued From page 27 stated daily temperature monitoring was still in place from COVID 19, as a nursing order. CNS-C confirmed R6's record did not include instructions for ULPs to report monitoring of temperature to nursing. CNS-C stated she thought daily temperature monitoring was required for COVID 19. PULSE R5 R5's diagnosis included chronic obstructive pulmonary disease (COPD/ a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), hypertension (HTN/high blood pressure), kidney disease, seizure disorder and chronic pain. R5's service plan dated March 27, 2024, included pulse daily. R5's prescriber's order dated January 14, 2025, included the following note: -manual BP daily. R5's prescriber order dated January 6, 2025, included, "I" (prescriber) recommend daily blood pressure and heart rate (pulse) monitoring at the patient's assisted living facility until her follow up appointment with her PCP (primary care provider). I recommend the patient follow up with her PCP within seven days of discharge for close follow up. R5's master care plan dated January 29, 2025, included: cardiac function -elevated blood pressure: medication to control. R5 sees a cardiologist regularity to monitor. Cardiologist would like blood pressure to be 135/80 or lower.	01420		

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01420	Continued From page 28 R5's assessment dated February 10, 2025, noted: -history of bradycardia (slow heart rate/pulse). R5's vital signs report dated January 13, 2025, through February 13, 2025, indicated R5's pulse ranged from 49-80. R5's scheduled services dated February 1, 2025, through February 10, 2025, included: -record pulse. On February 13, 2025, at 10:45 a.m., the surveyor reviewed R5's record with CNS-C. CNS-C stated R5's pulse ran low. CNS-C confirmed R5's record did not include instructions for ULPs to report monitoring of R5's pulse. WEDGE R9 R9's diagnosis included pulmonary empyema (a serious lung condition that occurs when pus builds up in the pleural space, the cavity between the lung and the chest wall). R9's service plan dated July 24, 2024, indicated R9 received the following services: bathing assist, dressing assist, exercise, grooming assist, medication administration, vital sign monitoring, toileting, transfer assist, and housekeeping services. R9's Rtask service record noted, position/re-position, active November 19, 2024: -reposition resident every two hours. On February 11, 2025, at 7:40 a.m., the surveyor observed ULP-B and ULP-D answer an alarm that sounded from R9's bed. ULP-B assisted R9 into a wheelchair and took R6 to a nearby	01420		

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01420	Continued From page 29 bathroom. The surveyor observed a wedge type of pad/cushion in R9's room. ULP-B had taken one of the wedge type of pad/ cushions with her when she took R9 to the bathroom. ULP-D stated the wedges were used on R9's right side as R9 leans and the wheelchair used is wide for R9. ULP-D stated ULPs place the wedge in R9's wheelchair so R9 does not tip over while in the kitchen (having breakfast). ULP-D added R9's face will "balloon" when her face is leaning. On February 11, 2025, at 7:52 a.m., the surveyor observed R9 seated at the table in a wheelchair with the wedge cushion/pad placed along R9's right side. On February 11, 2025, at 9:15 a.m., CNS-C stated it was highly doubtful that R9's record included any instructions for the wedge/pad/cushion used in R9's wheelchair. CNS-C said she was not aware of the wedge/cushion and added hospice must have brought the wedges in for R9. CNS-C stated the wedge/cushion would be benefit to R9 and confirmed R9's record did not include and instructions for the use of R9's chair wedge/cushion. The licensee's Delegation of Assisted Living Services policy date November 29, 2021, noted a registered nurse (RN) or licensed health professional at the facility my delegate tasks only to staff would are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. -A RN may delegate nursing services to a person who had successfully completed staff orientation, who had been trained in the service to be provided, and who had demonstrated to the RN	01420		

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01420	Continued From page 30 the ability to competently follow the procedures for the resident. These services include, but are not limited to: -treatment and therapies -assisting residents with eating when the residents have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed -providing other complex or specially health care services -provide nutritional needs -specify, in writing, specific instructions for each resident and document those instructions in the resident's record. Performing routine delegated medical or nursing procedures, such as: -catheter procedures, care and cleaning -blood pressure checks -wound care procedures -splints -thickened liquid preparation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500		

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01500	Continued From page 31 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	01500		

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01500	Continued From page 32 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS-C). 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: CNS-C was hired on September 10, 2002, to oversee direct care staff and to provide direct care services to the licensee's residents. On February 10, 2025, at 9:35 a.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the licensee. On February 10, 2025, at approximately 4:30 p.m., the surveyor observed CNS-C on the phone	01500		

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01500	Continued From page 33 discussing a possible hospital return of a resident. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 10, 2025, at 3:53 p.m., LALD-A stated the principles of person-centered planning and service delivery was not assigned to CNS-C. LALD-A stated the "book" (assisted living statues guide) noted only "direct care staff" required this training topic. In addition, LALD-A stated the Educare form (on-line training system used) did not list the principles of person-centered planning as a required training for the CNS on the guideline form used by the licensee. LALD-A confirmed CNS-C had not completed the principles of person-centered planning training. The licensee's Annual Required Staff Training policy dated December 14, 2021, noted the following training elements MUST be included every 12 months to all staff who performed direct care services: -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 34 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01530		

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01530	Continued From page 35 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F was hired on October 21, 2024, to provide direct care services under the Assisted Living Facility license. On February 11, 2025, at 5:49 a.m., the surveyor observed ULP-F answer R9's pager. ULP-F's record included the following dementia related training: - dementia, activities, a balanced approach, dated November 6, 2024, 0.75 hour (forty-five minutes) - dementia, activities, hydration, nutrition, eating and dining, dated November 6, 2024, 0.75 hour - dementia, communication, overview, dated November 6, 2024, one hour (sixty minutes) - dementia, communication, reality and validation, dated November 6, 2024, 0.75 hour - dementia, overview, overview, dated November 6, 2024, one hour - dementia, person-centered care, dated November 6, 2024, 0.75 hour - dementia, problem solving, anger and aggression, dated November 6, 2024, 0.5 hour (thirty minutes) - dementia, problem solving, overview, dated November 6, 2024, 0.75 hour. ULP-F's record included a total of 6.25 hours of dementia training. ULP-F's employee record did not include a total of eight hours of the required dementia training	01530		

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01530	Continued From page 36 completed within 160 hours of the employee's start date. On February 11, 2025, at 10:13 a.m., licensed assisted living director (LALD)-A stated ULP-F had worked 188 hours at the facility. LALD-A further stated that total included ULP-F's Educare hours (training hours). LALD-A added she was not aware that the dementia hours were needed, within the hours of an employee's start date. LALD-A added she had delegated the task to assign classes to another staff, and that person must have assumed all of the classes assigned were an hour in length. LALD-A stated ULP-F had not completed the required dementia training. The licensee's Dementia Training policy dated December 14, 2021, noted direct care employees would complete eight hours of initial training within 160 hours of the employment start date. Employees may not provide direct care until the training was complete unless another employee who had completed the initial training was present to provide assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and	01560		

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01560	Continued From page 37 other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. 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: On February 10, 2025, at 3:37 p.m., R5's contract and required documentation was reviewed with licensed assisted living director (LALD)-A. LALD-A stated she "got a bit confused" and thought dementia training program information provided to residents was only required with dementia license. LALD-A stated the licensee did	01560		

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01560	Continued From page 38 not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form available to consumers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 39 Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for two of two residents (R5, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5 R5's diagnoses included depression, back pain, seizure disorder, hypertension (HTN/high blood pressure), chronic respiratory failure, chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs) and anxiety. R5's service plan dated March 27, 2024, included the following services: - ambulation - compression stockings (TEDS) - exercise - grooming - toileting - transfer assistance - hearing aides - medication administration - oxygen delivery - blood pressure, two times daily - oxygen saturation, three times daily - pulse, daily - temperature, daily - weight, one day a week	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30761	A. BUILDING: _____ B. WING _____	02/13/2025

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01640	Continued From page 40 - skin care, twice daily. R5's prescriber's order dated January 14, 2025, included: - manual blood pressure daily - weight daily. R5's individualized treatment and therapy pan dated February 1, 2025, included - record blood pressure two times daily, supervision of blood pressure management. Notify MD (medical doctor) if higher than 135/80. R5's Treatment recap summary dated February 1, 2025, through February 10, 2025, included: - record blood pressure, 8:00 a.m., - skin treatment, 8:00 a.m., - record weight, 10:00 a.m. - record blood pressure, 8:00 p.m. - skin treatment, 8:00 p.m. - TEDS - exercise - oxygen delivery. On February 10, 2025, at 12:49 p.m., the surveyor observed unlicensed personnel (ULP)-B go to R5's room. R5 was seated in a recliner. ULP-B gather supplies to include a brief and liner. ULP-B applied a gait belt around R5's waist and assisted R5 to the bathroom. While on the toilet, ULP-B adjusted R5's TEDS. R5 was not observed to be using oxygen. On February 10, 2025, at 3:05 p.m., the surveyor reviewed R5's service plan with clinical nurse supervisor (CNS)-C. CNS-C stated services were updated in the computer system; however, she does not print out updated service plans and have residents sign them as services change. CNS-C added she used to use an addendum	01640		

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01640	Continued From page 41 form when services changed instead of printing out the complete service plan. CNS-C stated it made sense to have residents acknowledge changes in services. CNS-C stated she had not made service plan revisions when changes in services occurred, and it would be a widespread issue. R8 R8's diagnoses included chronic obstructive pulmonary disease COPD. R8's service plan dated March 16, 2023, indicated R8 received the following services: - oxygen delivery, three times daily - medication administration - dressing (evening) - temperature monitoring, four times daily - information, three times daily - symptom screen 2, three times daily - symptom screen 1, three times daily - meal assist, daily. On February 13, 2025, at 8:09 a.m., the surveyor observed ULP-G enter R8's room and inform R8 of breakfast. R8 stood from R8's recliner. The surveyor observed a nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) on the arm of R8's recliner. ULP-G turned off the oxygen concentrator, and commented, "he (R8) always leaves it (oxygen concentrator) on." On February 13, 2025, at 10:50 a.m., R8's service plan was reviewed with CNS-C. CNS-C stated R8's service plan was old. CNS-C stated she used, "information" for items that she could not remember. CNS-C confirmed the service plans were not updated with changes, or signed	01640		

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01640	Continued From page 42 by residents or their representatives. The licensee's Service Plan Modifications policy dated November 28, 2021, noted if the service plan needed to be modified due to a change in a prescriber's order or a change in the resident's needs, the service plan medication form would be completed; this form included: - describe changes in service and whether the service is added (new), changed, or discontinued - frequency of new service or if service terminated - identification of the staff would perform the service - scheduled and methods of monitoring staff - fee for the service - date/signature of RN (registered nurse) making changes - date/signature of resident (or the resident's representative each time a modification was made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750		

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01750	Continued From page 43 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R5, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: R5 R5's diagnosis included chronic obstructive pulmonary disease (COPD/a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), hypertension (HTN/high blood pressure), kidney disease, seizure disorder, and chronic pain. R5's service plan dated March 27, 2024, included medication administration. R5's medication administration record dated February 1, 2025, through February 9, 2025, included:	01750		

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01750	Continued From page 44 - acetaminophen, give one rectal suppository every four hours, PRN (as needed, as desired) - acetaminophen 325 milligrams (mg) give two tablets by mouth every six hours PRN - Benefiber, give in juice daily for constipation, PRN - Peg 3350, 17-gram powder Soln (solution), take 17 grams (one capful) by mouth daily PRN for constipation (MiraLAX). R5's prescriber order dated January 14, 2025, included the above orders. On February 11, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-D apply an automatic blood pressure (BP) cuff around R5's left arm. ULP-D instructed R5 to sit up and started the BP machine to obtain a reading of 138/71. On February 10, 2025, at 3:25 p.m., the surveyor reviewed R5's MAR with clinical nurse supervisor (CNS)-C. CNS-C stated she was not sure why, but R5's MAR was different when printed out then what it looked like when the ULPs used the MAR on the computer. CNS-C and the surveyor reviewed the form that was sent to the ER (emergency room). CNS-C stated the form did not include complete instructions and complete instructions should be printed on the MAR. CNS-C stated that when the licensee transitioned to the on-line system currently used, she (CNS-C) was not able to enter/add medication. CNS-C stated she gave a list of the licensee's standing orders a person who worked for the computer system, and they entered them. CNS-C stated complete instructions were not included for each PRN medication. CNS-C stated she was pretty sure the ULPs knew that acetaminophen was used for pain. CNS-C added MiraLAX was not on	01750		

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01750	Continued From page 45 the licensee's standing orders; however, R5's MAR should have included, MiraLAX mix with water and an amount. CNS-C stated she missed R5's MiraLAX. On February 10, 2025, at 4:35 p.m., CNS-C stated all the standing order medications would be missing specific directions. CNS-C stated this was a wide spread issue. The manufacturer's instructions Benefiber dated 2023, included stir two teaspoons of Benefiber Original into four to eight ounces of beverage or soft food (hot or cold). Stir well until dissolved, (up to 60 seconds). Not recommended for carbonated beverages. The manufacturer's instructions for polyethylene glycol 3350 dated 2025, included, add the right dose to four to eight ounces of water, juice, soda, coffee or tea. Do not mix this medication with foods or other liquids. R4 R4's diagnosis included diabetes, COPD, HTN, anxiety disorder, and polysubstance abuse. R4's service plan dated March 27, 2024, included medication administration. R4's MAR dated January 1, 2025, through January 31, 2025, included: -Trelegy, (COPD) inhale one puff into the lungs daily. R4's prescriber order dated April 4, 2024, included the above order. On February 11, 2025, at 8:12 a.m., the surveyor observed ULP-B hand R4 a medication cup	01750		

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01750	Continued From page 46 containing oral medication. R4 swallowed the oral medication and drank water. ULP-B placed a Trelegy inhaler near R4. R4 picked up the inhaler, drank more water, and used the inhaler. ULP-B handed R4 nasal spray and R4 instilled the nasal spray. R4 picked up the water and drank from the cup and coughed. ULP-B completed a blood sugar check, and R4 continued to cough. ULP-B asked R4 if she would like some more water. On February 11, 2025, at 8:20 a.m., the surveyor reviewed R4's MAR with ULP-B. ULP-B stated R4's MAR did not include instructions to rinse their mouth out after Trelegy use. ULP-B picked up the Trelegy inhaler box and read the box. ULP-B stated she never knew that (Trelegy required rinsing after use.) On February 11, 2025, at 9:08 a.m., the surveyor reviewed R4's MAR with CNS-C. CNS-C stated she did not include the instruction to have R4 rinse her mouth after inhaler administration, "I missed that" (direction in R4's record). The manufacturer's instructions for Trelegy Ellipta dated February 10, 2025, noted to prevent yeast infection in your mouth, rinse with water (but do not swallow) after using Trelegy Ellipta. The licensee's Medication & Treatment-Administration & Delegation policy dated November 29, 2021, noted when administration of medication or treatment/therapy was delegated or assigned to unlicensed personnel, the license would ensure that the registered nurse had: -instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had	01750		

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01750	Continued From page 47 demonstrated the ability to competently follow the procedures -specified, in writing, specific instructions for each resident and documented those instruction in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-B). In addition, the licensee failed to ensure medications were administered as ordered for one of four residents (R8) who received medication management services.	01760		

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01760	Continued From page 48 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: STEPS OF THE MEDICATION ADMINISTRATION PROCESS R8 R8's diagnosis included COPD, HTN, anxiety, and constipation. R8's service plan dated March 16, 2023, included medication administration. R8's MAR dated February 1, 2025, through February 11, 2025, included: - Allegra 180 mg, (allergies) - folic acid one mg, (supplement) - probiotic one, (gut health/supplement) - vitamin B-12 1000 mg, (supplement) - vitamin D3 50 micrograms (mcg), (Supplement). R8's prescriber order dated March 28, 2024, included the above orders. On February 11, 2025, at 7:54 a.m., the surveyor observed ULP-B prepare R8's morning oral medication and take the medication to R8's room. The surveyor observed an opened bottle of Systane eye drops (dry eyes) on a side table in R8's room. ULP-B administered R8's oral	01760		

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01760	Continued From page 49 medication. On February 11, 2025, at 7:58 a.m., ULP-B picked up the eye solution from R8's side table and instilled a drop of Systane eye solution (dry eyes) into each of R8's eyes. On February 11, 2025, at 8:03 a.m., ULP-B walked past the medication preparation area and went to the kitchen, moved a pan, and talked to another staff member. On February 11, 2025, at 8:06 a.m., the surveyor asked ULP-B about the documentation of R8's medication. ULP-B stated she had not documented R8's medications yet, and added she (ULP-B) should have documented R8's medication as administered "on her way through" prior to going to the kitchen. MEDICATION ERROR R8's prescriber order dated March 28, 2024, did not include Systane eye solution. On February 11, 2025, at 8:06 a.m., the surveyor asked ULP-B about the documentation of R8's Systane eye solution. The surveyor did not observe ULP-B document R8's Systane eye solution as administered. ULP-B stated, "it might be [R8's] normal thing. [R8] states, 'I need my eye drop,'" and the ULP administers R8's eye solution. ULP-B reviewed R8's MAR with the surveyor and was not able to locate Systane eye solution on R8's MAR. On February 11, 2025, at 8:07 a.m., ULP-D stated R8's family told R8 he could keep the eye solution in his room. On February 11, 2025, at 9:12 a.m., clinical nurse	01760		

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01760	Continued From page 50 supervisor (CNS)-C stated she did not know R8 had Systane eye solution in his room. CNS-C further stated R8 did not have an order for the Systane eye solution, and the ULP should not have administered R8's Systane eye solution and that a medication error had occurred. The licensee's Medication & Treatment-Administration & Delegation policy dated November 29, 2021, noted when administration of medication or treatment/therapy was delegated or assigned to unlicensed personnel, the license would ensure that the registered nurse had: instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures The RN must instruct the ULP on the following medication administration tasks before delegating the task to them: - the complete procedure of checking a resident's medications administration record (MAR) - the preparation of medications for administration - the administration of the medication to the resident - the documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medication, or the reason for not assisting with mediation administration as ordered, and the initials of the nurse of authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 51 days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was securely stored and permitted only authorized personnel to have access to medication being stored by the licensee for two of five residents (R2, R8). 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: SHOWER ROOM On February 10, 2025, at 10:37 a.m. during a tour of the facility with clinical nurse supervisor (CNS)-C, the surveyor observed several clear plastic bins of personal care items stacked on a shelf in an unlocked bathroom, labeled "shower room." In one of the bins, there was an	01880		

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01880	Continued From page 52 unsecured, opened tube of nystatin cream 1000.00 % (yeast/antifungal) for R2. CNS-C stated R2's nystatin cream should not have been in the "shower room" unsecured. CNS-C removed R2's nystatin cream from the unlocked and unsecured bathroom/shower room. RESIDENT ROOM R8's diagnosis included chronic obstructive pulmonary disease (COPD/ a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), hypertension (HTN/high blood pressure), anxiety, and constipation. R8's service plan dated March 16, 2023, indicated R8 received the following services: medication administration. R8's assessment dated February 10, 2025, included: medication management - all medications are locked in the medication carts and only accessible to staff. R8's medication administration record dated February 1, 2025, through February 10, 2025, noted: - Metamucil, give in juice daily for constipation, as needed (PRN) R8's prescriber order dated March 28, 2024, included the above order. On February 13, 2025, at 8:09 a.m., the surveyor observed unlicensed personnel (ULP)-G go to R8's room, announce breakfast and turn off R8's oxygen concentrator. The surveyor observed a container of Metamucil, which was approximately one third full on a side table in R8's room.	01880		

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HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

(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
01880	Continued From page 53 On February 13, 2025, at 8:36 a.m., CNS-C stated she was not aware R8 had medication in his room. CNS-C further stated R8's family brings in R8's medication, and the Metamucil should have been secured. The licensee's Medication Storage policy dated November 29, 2021, noted medication managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medications room, medications cart, or similar setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for two of two medication carts (Side One, Side Two).	01890		

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01890	Continued From page 54 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 10:10 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C, to include a review of the locked medication carts. CNS-C observed and confirmed the following: SIDE ONE - an opened Trelegy Ellipta inhaler (asthma) 200/62, 5/25 micrograms (mcg) for R4 was not dated - an opened Refresh dry eye solution for R4 was not dated - an opened Reliva Refresh eye solution (dry eyes) for R2 was dated January 28, 2025, but no expiration date was noted; - an opened Systane Gel drops (dry eyes), date was not legible, for R3. SIDE TWO -an opened Trelegy Ellipta inhaler 200/62, 5/25 mcg for R5 dated February 9, 2025, but no expiration date was noted -an opened Advair Diskus inhaler (asthma) 250/50 mcg for R10, dated January 21, 2025, but no expiration date was noted. Directly after the above observation, the insert for R4's Refresh eye solution was reviewed with	01890		

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01890	Continued From page 55 CNS-C. CNS-C stated R4's Refresh was not dated as required. In addition, CNS-C stated she was not able to read the writing on R3's Systane Gel, "it has worn off." CNS-C stated the licensee had a widespread issue with dating time sensitive medications. The manufacturer's instructions for Trelegy Ellipta dated February 10, 2025, indicated to store the device in the unopened tray and only open when ready for use. Safely throw away Trelegy Ellipta in the trash six weeks after you open the tray or when the counter reads "0" whichever comes first. Write the date you open the tray on the label on the inhaler. The manufacturer's instructions for Refresh dry eye solution dated June 2022, included discard 90 days after opening. The manufacturer's instructions for Reliva Refresh dated March 1, 2024, included discard 90 days after opening. The manufacturer's instructions for Systane Gel dated 2022, included Systane Gel drops can be used for three months after opening. Always check the label for the expiration date. The manufacturer's instructions for Advair Diskus dated February 9, 2025, included store Advair Diskus in the unopened foil pouch and only open when ready for use. Safely throw away Advair Diskus in the trash one month after you open the foil pouch or when the counter reads 0, whichever comes first. The licensee's Medication Storage policy dated November 29, 2021, noted medications would be stored consistent with manufacturer's	01890		

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01890	Continued From page 56 recommendation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

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01940	Continued From page 57 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R7) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 10, 2025, at 9:50 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee provided treatment and therapy services to residents at the facility. R7 R7's diagnoses included fibromyalgia (condition that causes widespread muscle and joint pain), generalize anxiety disorder, asthma, rheumatoid arthritis, impaired mobility, and chronic back pain. R7's service plan dated March 27, 2024, indicated R7 received the following services: meal assistance three times daily, and transfer assist two times daily. R7's service plan did not include locomotion, or	01940		

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01940	Continued From page 58 modified diet. TILT-N-SPACE WHEELCHAIR (a wheelchair which has a seat that tilts backward while keeping the user's hips, knees, and ankles at 90 degrees) On February 10, 2025, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-D use a Hoyer lift (mechanical lift/ device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers, sling type) to transfer R7 out of bed and into tit-n-space wheelchair. R7's PT (physical therapy), OT (occupational), Speech Language Pathologist (SLP) recommendations to Caregiver dated November 12, 2024, noted: - OT discharged today from OT for goals met - writer still completing documentation coordination. Justification letter to MDCR (medical & dental medical insurance billing) for new modification tilt wheelchair recommend in meantime tilt back when not completing functional ADLs and use pillow under feet in footplates PRN (as desired for lower extremities positioning/pain) - make sure cushion is on right with zipper in back - expect follow up from MDCR in approximately four to eight weeks. R7's Master Care Plan dated December 26, 2024, included: Mobility-Wheelchair - needs assistance with wheelchair: staff propel wheelchair at all times. Per OT recommendations follow the following instructions: keep cushion on the wheelchair with zipper in the back for optimal wheelchair positioning. Once it arrives keep	01940		

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01940	Continued From page 59 padding to footbox of wheelchair on at all times for pressure sore prevention. Keep wheelchair tilted back to approximately 30 degrees when not doing something functional. Put a pillow under her feet while in her wheelchair. She will be getting modifications made to her wheelchair, but it will take four to eight weeks. type of wheeled device: manual wheelchair: they are working on some adjustments to her wheelchair due to weight gain. MODIFIED DIET On February 10, 2025, at 12:41 p.m., the surveyor observed ULP-B review R7's MAR and prepare R7's 1:30 p.m. medication. ULP-B took a medication cup of medication to R7 who was seated at the dining room table. ULP-B asked R7 if she (R7) was "worn out from coughing." ULP-B gave R7 the medication cup and picked up a cup of tea positioned near R7 with a straw. R7 took the medication whole and drank tea from the straw. R7's Aspiration Precautions dated October 28, 2024, authenticated by SLP, noted: - sit at 90 degrees while eating and remain seated 20 minutes after meals - tuck our chin down while swallowing - take small bites and sips - chew and swallow before taking another bite - alternate food and liquid throughout the meal - chop/cut foods into bite sized pieces at each meal - add moisture to dry or crumbly foods such as gravy, broth, mayo, other condiments - after meals, check for pocketing and clear and pocketed for - do oral care daily. Consider reintroducing dentures for better chewing.	01940		

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01940	Continued From page 60 R7's Master Care Plan dated December 26, 2024, included: Eating Needs-Feeding - recommended diet mechanical soft, thin liquids (straw ok) - sit at 90 degrees while eating and remain seated 20 minutes after meals - tuck our chin down while swallowing - take small bites and sips - chew and swallow before taking another bite - alternate food and liquid throughout the meal - chop/cut foods into bite sized pieces at each meal - add moisture to dry or crumbly foods such as gravy, broth, mayo, other condiments - after meals, check for pocketing and clear and pocketed for - do oral care daily. Consider reintroducing dentures for better chewing. Is there any difficulty swallowing- yes, swallow evaluation and study were done, and diet was altered. R7's RTasks Service: meal assistance, active April 15, 2020, noted: - DYSPHASIA (special eating plan, at risk for aspiration [food or liquid enters the lungs by accident] diet with all meals and snacks See MAR for treatments for DYSPHASIA before, during and after meals. R7's MAR dated February 1, 2025, through February 12, 2025, included: -gabapentin, (nerve pain) 100 milligrams (mg) take two capsules daily, "ok to open up and mix with pudding" -melatonin 5 mg, "ok to crush" -okay to have one alcoholic drink per day. Document if she had one on each shift, one ounce liquor, one beer, or five ounces of wine.	01940		

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01940	Continued From page 61 R7's MAR did not include dysphasia before, during and after meals, as noted above. R7's record did not include evidence of an individualized treatment management plan for R7's tit-n-space wheelchair or modified diet to include: - a written statement on the service plan of the treatment or therapy services that will be provided to the resident; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatment or therapy services. On February 13, 2025, at 8:31 a.m., R7's record was reviewed with CNS-C. CNS-C stated locomotion to include tilt-n-space wheelchair was not on R7's service plan. CNS-C stated R7's service plan did not include R7's modified diet; rather, the service plan only included meal assistance. CNS-C confirmed R7's record lacked to include a statement of services provided. The licensee's Treatment & Therapy Management Plan policy dated November 29, 2021, noted the license would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that would be provide - identification of the treatment or therapy tasks that would be delegated to unlicensed personnel - procedures for notifying a registered nurse (RN) or appropriate licenses health professional when a problem arose with treatment or therapy services - verification that all treatment and therapy was administered as prescribed.	01940		

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01940	Continued From page 62 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN)-B trained unlicensed personnel (ULP) to demonstrate the ability to follow the procedure to perform the tasks for two of two employees (ULP-F, ULP-E). In addition, the licensee failed to ensure instructions, specified in writing, for each resident and documented those instructions in the	01950		

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01950	Continued From page 63 residents' record for four of four residents (R5, R6, R7, R4) who received treatments. 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: During the entrance conference on February 10, 2025, at 9:50 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee provided treatment and therapy services to residents at the facility, to include compression stockings (TEDS), modified diets, and oxygen administration. ULP-F ULP-F was hired on October 21, 2024, to provide direct care services to residents of the facility. On February 11, 2025, at 5:49 a.m., the surveyor observed ULP-F answer R9's pager. On February 11, 2025, at 12:03 p.m., CNS-C stated ULP-F was hired to work the day shift; however, ULP-F was willing to work night shift if/when needed. ULP-F's training record did not include: - tilt-n-space wheelchair (a wheelchair which has a seat that tilts backward while keeping the user's hips, knees, and ankles at 90 degrees) - TEDS	01950		

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01950	Continued From page 64 - modified diets. ULP-E ULP-E was hired on July 25, 2023, to provide direct care services to residents of the facility. On February 11, 2025, at 6:04 a.m., the surveyor observed ULP-E and ULP-D perform a narcotic count. On February 11, 2025, at 12:03 p.m., CNS-C stated ULP-E was hired to work nights. CNS-C said that ULP-E would come in early for a partial afternoon shift. ULP-E's training record did not include: - tilt-n-space wheelchair -TEDS -modified diets. TILT-N-SPACE On February 11, 2025, at 9:44 a.m., CNS-C stated she did not train ULPs on Broda (tilt-n-space that has webbing to reduce moisture) or tilt-n-space wheelchairs. CNS-C stated she thought there were instructions/directions in resident's records (R7) for use of tilt-n-space wheelchair. CNS-C stated hospice had brought in a Broda wheelchair for one of the residents to use in the past. CNS-C added that resident had since passed away. CNS-C confirmed ULPs were not trained or deemed competent for specialized wheelchairs. TEDS and MODIFIED DIETS On February 11, 2025, at 10:01 a.m., the surveyor reviewed ULP-F's employee training record with CNS-C. CNS-C stated ULP-F's record did not include training and competency for TEDS, or modified diets. CNS-C stated she " bet"	01950		

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01950	Continued From page 65 the training for TEDS and modified diets was not on the form currently used by the licensee for training/testing. ULP-E's record was reviewed by CNS-C. CNS-C stated the same form was used for ULP-E as ULP-F. CNS-C stated if the skills were not listed on the form, the skills were not taught and competency was not completed. CNS-C confirmed ULP-E and ULP-F had not had training and were not deemed competent for TEDS. CNS-C stated some ULPs received modified diet training from occupational therapy (OT) or herself (CNS-C), but CNS-C could not confirm ULP-F or ULP-E had received the training and competency for modified diet as required On February 11, 2025, at 10:22 a.m., LALD-A stated the form used for ULP-F and ULP-E did not include TEDS or modified diet. LALD-A confirmed ULP-F and ULP-E had not completed required training. On February 13, 2025, at 8:07 a.m., LALD-A stated she was able to find modified diet training in a few ULP records, but not in ULP-F or ULP-E's records. INSTRUCTIONS IN RECORD R5 R5's diagnoses included major depressive disorder, heart disease, hypertension (HTN/high blood pressure), obesity, emphysema (air sacs in the lungs become damaged and stretched), and anxiety disorder. R5's service plan dated March 27, 2024, included the following services: - oxygen delivery - blood pressure (BP), two times daily. OXYGEN	01950		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 66 R5's master care plan dated January 29, 2025, included: respiratory equipment - needs help with oxygen equipment: yes, resident needs three liters per minute (LPM) per nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) to keep oxygen saturation above 90% continuously respiratory function - history of pneumonia. Due to COPD (chronic obstructive pulmonary disease/chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pneumonia, she (R5) has oxygen to keep saturation about 88%. She was recently hospitalized for pneumonia, she was septic. She went to skilled nursing after her hospital stay for rehab. R5's Treatment recap summary dated February 1, 2025, through February 10, 2025, included: - oxygen delivery. R5's Individual Abuse Prevention Plan dated January 29, 2025, noted: - needs help with oxygen equipment: yes, resident needs 3 LPM per NC to keep oxygen saturation above 90% continuously. R5's resident notes included: - dated January 10, 2025, her (R5) oxygen saturation was 94% on room air. She (R5) did not come back with oxygen on but saturation stayed above 88% - dated January 21, 2025, her oxygen saturation has been staying above 88% on room air most days, even when doing therapy. She does need her oxygen at times. R5's prescriber's order dated January 14, 2025,	01950		

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	30761	A. BUILDING: _____ B. WING _____	02/13/2025

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01950	Continued From page 67 included the following note: - dated January 6, 2024, patient is back on her baseline level of oxygen (2 LPM) On February 10, 2025, at 12:49 p.m., the surveyor observed ULP-B go to R5's room. R5 was seated in a recliner. ULP-B gathered supplies to include a brief and liner. ULP-B applied a gait belt around R5's waist and assisted R5 to a bathroom. While on the toilet, ULP-B adjusted R5's TEDS. The surveyor did not observe R5 using oxygen. R5's record included oxygen monitoring from January 13, 2025, through February 13, 2025: - out of 93 opportunities R5's oxygen saturations ranged between 82% to 99% - two entries, noted, room air - three entries, noted, put oxygen on - one entry, noted, saturation ranging 88-92%, two liters oxygen applied. On February 12, 2025, at 3:43 p.m., ULP-B stated R5 had an order for oxygen and could use it when R5 wanted too. ULP-B further stated R5 did not wear oxygen on February 11, 2025. On February 12, 2025, at 3:50 p.m., the surveyor and ULP-B reviewed R5's record. ULP-B was not able to find "anything, other than in care plan to use oxygen to keep saturation at 90%." (The day prior the surveyor had requested R5's care plan, and the care plan noted to keep saturation at 88%). R5's record did not include specific instruction in R5's record for oxygen administration. On February 13, 2025, at 9:19 a.m., CNS-C stated R5 should have oxygen on at all times.	01950		

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01950	Continued From page 68 CNS-C stated R5's record did not include specific instructions for oxygen use. In addition, CNS-C stated ULPs should have included in R5's oxygen monitoring if oxygen was in use or not, every time documentation occurred. BP On February 11, 2025, at 7:50 a.m., the surveyor observed ULP-D apply an automatic BP cuff around R5's left arm. ULP-D instructed R5 to sit up and ULP-D started the BP machine to obtain a reading of 138/71. R5's prescriber's order dated January 14, 2025, included the following note: -manual BP daily. R5's individualized treatment and therapy plan dated February 1, 2025, included -record BP two times daily -supervision (RN) of BP management. Notify MD (medical doctor) if higher than 135/80. R5's RTasks (computer system used) service active August 2, 2021, noted: -check/record BP daily. R5's record included BP monitoring from January 13, 2025, through February 13, 2025: - R5's blood pressure had been monitored 63 times - BPs ranged from 156/77, 125/55, 149/94. R5's record did not include specific instruction in R5's record for BP monitoring. On February 13, 2025, at 10:27 a.m., R5's record was reviewed with CNS-C. CNS-C stated R5's record should have more instructions for staff.	01950		

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01950	Continued From page 69 CNS-C stated she can't remember ULPs ever contacting her with low BP readings. CNS-C stated she reviewed BP results weekly. CNS-C confirmed R5's record did not include parameters of what and when ULPs should notify her. R6 R6's diagnoses included multiple sclerosis (MS/chronic autoimmune disease that affects the central nervous system (brain and spinal cord). R6's service plan dated August 23, 2024, indicated R6 received skin treatment daily. On February 10, 2025, at 1:04 p.m., the surveyor observed ULP-B and ULP-D use a Hoyer lift (mechanical lift/ device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers, sling type) to transfer R6 from an electric wheelchair into a hospital bed. The surveyor observed a bottle of wound cleaner, and an assortment of wound dressings in R6's room. R6's Rtasks, skin treatment active December 9, 2024, noted: -cleanse wound and around the wound with Saline Spray. Pack wound and undermining (under the edges of the wound where there is a lip) with Maxorb AG (antimicrobial wound dressing). Cover with four-inch Allevyn dressing (foam dressing designed for wound management and prevention). Put half of an ABD (abdomen) pad over the Allevyn dressing to prevent it from getting soiled. Place a piece of gauze in her buttocks to prevent dressing from getting soiled as well. Change every other day and as needed if it comes off or becomes soiled. Home care will change it Tuesday and Friday. We will change it	01950		

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01950	Continued From page 70 in the afternoon on shower days (Wednesday and Sunday). R6's prescriber order dated December 2, 2024, included: -cleanse with saline spray. Pack wound and undermining with Maxorb AG. Cover with four-inch Allevyn. Change every other day. R6's prescriber order dated January 29, 2025, included: -wound looks great!! Continue current treatment plan. Follow up in one month. R6's record did not include specific instruction in R6's record for skin treatment/wound care. On February 10, 2025, at 4:05 p.m., R6's record was reviewed with CNS-C. CNS-C stated an outside home care agency came into the facility two days a week and the licensee's ULPs performed wound care on other days. CNS-C stated R6's record did not include specific instructions for ULPs to report to nursing such as signs and symptom of infection, to include odor, drainage, or increased pain. R7 R7's diagnoses included fibromyalgia (condition that causes widespread muscle and joint pain), generalize anxiety disorder, asthma, rheumatoid arthritis, impaired mobility and ADLs (activities of daily living) unable to ambulate, and chronic back pain. R7's service plan dated March 27, 2024, indicated R7 received the following services: meal assistance three times daily, and transfer assist two times daily.	01950		

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01950	Continued From page 71 R7's service plan did not include locomotion. TILT-N-SPACE WHEELCHAIR On February 11, 2025, at 7:22 a.m., the surveyor observed ULP-B and ULP-D transfer R7 with aid of a Hoyer lift into a tilt-n-space wheelchair. ULP-B stated there was a head rest for the wheelchair but R7 did not use the head rest and the head rest maybe in R7's closet. R7 stated it was possible the headrest was not left on the wheelchair as "it (headrest) maybe did not work for her (R7). R7's PT (physical therapy), OT (occupational), Speech Language Pathologist (SLP) recommendations to Caregiver dated November 12, 2024, noted: -OT discharged today from OT for goals met -write still completing documentation coordination. Justification letter to MDCR (medical & dental medical insurance billing) for new modification tilt wheelchair recommend in meantime tilt back when not completing functional ADLS and use pillow under feet in footplate's, PRN (for lower extremities positioning/pain) -make sure cushion on right with zipper in back -expect follow up from MDCR approximately four to eight weeks. R7's Master Care Plan dated December 26, 2024, included: Mobility-Wheelchair -needs assistance with wheelchair: staff propel wheelchair at all times. Per OT recommendations follow the following instructions: keep cushion on the wheelchair with zipper in the back for optimal wheelchair positing. Once it arrives keep padding to footbox of wheelchair on at all times for pressure sore prevention. Keep wheelchair tilted	01950		

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01950	Continued From page 72 back to approximately 30 degrees when not doing something functional. Put a pillow under her feet while in her wheelchair. She will be getting modifications made to her wheelchair, but it will take four to eight weeks. R7's record did not include specific instructions for the tilt-n-space wheelchair. On February 11, 2025, at 11:57 a.m., R7's record was reviewed with CNS-C. CNS-C stated R7's service plan did not include locomotion as a service. CNS-C stated locomotion did not "pop up" (generate) for ULPs to read any special instructions, to include tilt-n-space wheelchair. CNS-C stated ULPs would have to go into R7's master care plan to see any instructions for R7's tilt-n-space wheelchair. CNS-C stated tasks for ULPs did not include R7's tilt-n-space wheelchair or any specific instructions. MODIFIED DIET On February 10, 2025, at 12:41 p.m., the surveyor observed ULP-B review R7's MAR and prepare R7's morning medication. ULP-B took a medication cup of medication to R7 who was seated at the dining room table. ULP-B asked R7 if she was "worn out from coughing." ULP-B gave R7 the medication cup and picked up a cup of tea positioned near R7 with a straw. R7 took the medication whole and drank tea from the straw. R7's Aspiration Precautions dated October 28, 2024, authenticated by SLP, noted: -sit at 90 degrees while eating and remain seated 20 minutes after meals -tuck our chin down while swallowing -take small bites and sips -chew and swallow before taking another bite -alternate food and liquid throughout the meal	01950		

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01950	Continued From page 73 -chop/cut foods into bite sized pieces at each meal -add moisture to dry or crumbly foods such as gravy, broth, mayo, other condiments -after meals, check for pocketing and clear and pocketed for -do oral care daily. Consider reintroducing dentures for better chewing. R7's Master Care Plan dated December 26, 2024, included: Eating Needs-Feeding -recommended diet mechanical soft, thin liquids (straw ok) -sit at 90 degrees while eating and remain seated 20 minutes after meals -tuck our chin down while swallowing -take small bites and sips -chew and swallow before taking another bite -alternate food and liquid throughout the meal -chop/cut foods into bite sized pieces at each meal -add moisture to dry or crumbly foods such as gravy, broth, mayo, other condiments -after meals, check for pocketing and clear and pocketed for -do oral care daily. Consider reintroducing dentures for better chewing. Is there any difficulty swallowing- yes, swallow evaluation and study were done, and diet was altered. R7's RTasks Service: meal assistance, active April 15, 2020, noted: -DYSPHASIA (special eating plan, at risk for aspiration [food or liquid enters the lungs by accident] diet with all meals and snacks See MAR for treatments for DYSPHASIA before, during and after meals.	01950		

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01950	Continued From page 74 R7's MAR dated February 1, 2025, through February 12, 2025, included: -gabapentin, (nerve pain) 100 milligrams (mg) take two capsules daily, "ok to open up and mix with pudding" -melatonin (sleep) 5 mg, "ok to crush" -okay to have one alcoholic drink per day. Document if she had one on each shift, one ounce liquor, one beer, or five ounces of wine. R7's MAR did not include dysphasia before, during and after meals, as noted above. On February 13, 2025, at 8:30 a.m., CNS-C stated R7 was able to take some medications whole, the smaller medications. On February 13, 2025, at approximately 11:00 a.m., CNS-C stated instructions should be clear and easy to find in resident records to include what and when to report issues or concerns to nursing. CNS-C confirmed R7's record did not include specific instructions in R7's MAR. R4 R4's diagnoses included diabetes, anxiety disorder, addiction problems completed alcohol treatment, respiratory failure, and COPD. R4's service plan March 27, 2024, included: - daily blood glucose (BG) monitoring - BP three times per day. R4's prescriber order dated April 3, 2024, included: - BG daily - BP monitoring three times daily. On February 11, 2025, at 8:11 a.m., the surveyor observed ULP-B administer R4's morning medication. ULP-B removed a finger poke blood	01950		

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01950	Continued From page 75 glucose system from a pouch. ULP-B cleaned R4's pointer finger of left hand and used a lancet to get a drop of blood. ULP-B placed the blood onto a testing strip which ULP-B had inserted into the BG meter to obtain a reading of 146. BG R4's RTasks active June 14, 2022, noted: wearing gloves and following agency procedure, check BG and record. R4's BG reading dated January 11, 2025, through February 11, 2025, ranged between 84 to 327. On February 11, 2025, at 8:20 a.m., R4's MAR was reviewed with ULP-B. ULP-B stated R4's MAR did not include what type of BG monitoring was used, or specific instructions for BG monitoring. In addition, R4's record did not include what or when to report to nursing. On February 13, 2025, at 8:37 a.m., CNS-C indicated instructions should be easy to locate and ULPs should not have to look in the master care plan to find out what BG to report. BLOOD PRESSURE R4's RTasks active February 11, 2025, noted: check/record BP one hour after taking medications. R4's BP reading dated January 11, 2025, through February 11, 2025, ranged between 179/72, 93/57, 152/111, and 129/40. On February 12, 2025, at 4:01 p.m., R4's record was reviewed with ULP-B. ULP-B stated there were no instructions of what/when to report R4's BP, just to take it one hour after medication administration	01950		

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01950	Continued From page 76 R4's record did not include specific instruction for BP monitoring. On February 13, 2025, at 10:45 a.m., CNS-C stated R4's record only instructed to take and record R4's BP after meals. CNS-C stated R4's record did not include specific instructions for R4's BP monitoring as required. The licensee's Medication & Treatment-Administration & Delegation policy dated November 29, 2021, noted when administration of medication or treatment/therapy was delegated or assigned to unlicensed personnel, the license would ensure that the registered nurse had: - instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures - specified, in writing, specific instructions for each resident and documented those instruction in the resident's records. The licensee's Delegation of Assisted Living Services policy date November 29, 2021, noted a RN or licensed health professional at the facility my delegate tasks only to staff would are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. -A RN may delegate nursing services to a person who had successfully completed staff orientation, who had been trained in the service to be provided, and who had demonstrated to the RN the ability to competently follow the procedures	01950		

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01950	Continued From page 77 for the resident. These services include, but are not limited to: -treatment and therapies -assisting residents with eating when the residents have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed - providing other complex or specially health care services - provide nutritional needs - specify, in writing, specific instructions for each resident and document those instructions in the resident's record. Performing routine delegated medical or nursing procedures, such as: - use of glucometers oxygen administration -wound care procedures. The licensee's Treatment & Therapy Management Plan policy dated November 29, 2021, noted the license would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that would be provide - identification of the treatment or therapy tasks that would be delegated to unlicensed personnel -procedures for notifying a RN or appropriate licenses health professional when a problem arose with treatment or therapy services - verification that all treatment and therapy was administered as prescribed. No further information was provided.	01950		

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01950	Continued From page 78 TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included major depressive disorder, heart disease, hypertension (HTN/high	01960		

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01960	Continued From page 79 blood pressure), obesity, emphysema (air sacs in the lungs become damaged and stretched), and anxiety disorder. R5's service plan dated March 27, 2024, included the following services: - oxygen delivery - oxygen saturation, three times daily - blood pressure, two times daily. On February 11, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-D apply an automatic blood pressure cuff around R5's left arm. ULP-D instructed R5 to sit up and started the BP machine to obtain a reading of 138/71. The surveyor did not observe R5 wearing a nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen). OXYGEN R5's master care plan dated January 29, 2025, included: respiratory equipment - needs help with oxygen equipment: yes, resident needs 3 liters per minute (LPM) per NC to keep oxygen saturation above 90% continuously. respiratory function - history of pneumonia. Due to COPD (chronic obstructive pulmonary disease/chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pneumonia, she has oxygen to keep saturation above 88%. She was recently hospitalized for pneumonia, she was septic. She went to skilled nursing after her hospital stay for rehab. R5's Treatment recap summary dated February 1, 2025, through February 10, 2025, included:	01960		

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	30761	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

(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
01960	Continued From page 80 - oxygen delivery. R5's Individual Abuse Prevention Plan dated January 29, 2025, noted: - needs help with oxygen equipment: yes, resident needs 3 LPM per NC to keep oxygen saturation about 90% continuously. R5's resident notes included: - dated January 10, 2025, her (R5) oxygen saturation was 94% on room air. She (R5) did not come back with oxygen on, but STATS (oxygen saturation) stayed about 88% - dated January 21, 2025, her (R5) oxygen saturation has been staying above 88% on room air most days, even when doing therapy. She does need her oxygen at times. R5's prescriber's order dated January 14, 2025, included the following note: - dated January 6, 2024, include patient is back on her baseline level of oxygen (2 LPM). On February 12, 2025, at 3:43 p.m., ULP-B stated R5 had an order for oxygen and R5 could wear oxygen when R5 wanted to wear oxygen. ULP-B further stated R5 did not wear oxygen on February 11, 2025. On February 12, 2025, at 3:50 p.m., the surveyor and ULP-B reviewed R5's record. ULP-B was not able to find "anything, other than to use oxygen to keep saturation at 90%, in R5's care plan. (The day prior the surveyor had requested care plan, and the care plan noted to keep saturation at 88%). On February 13, 2025, at 9:19 a.m., clinical nurse supervisor (CNS)-C stated R5 should have oxygen on at all times. CNS-C confirmed oxygen	01960		

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01960	Continued From page 81 was not administered as ordered for R5. BLOOD PRESSURE R5's prescriber's order dated January 14, 2025, included the following note: - manual blood pressure (BP) daily. R5's individualized treatment and therapy plan dated February 1, 2025, included - record blood pressure two times daily, supervision of blood pressure management. Notify MD (medical doctor) if higher than 135/80. On February 13, 2025, at 8:40 a.m., CNS-C stated she missed the "manual" blood pressure order. CNS-C confirmed R5's treatments were not administered as prescribed. The licensee's Medication & Treatment Orders-Implementing policy dated November 29, 2021, noted upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other	01970		

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HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

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01970	Continued From page 82 information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R8) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8's diagnoses included chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs). R8's service plan dated March 16, 2023, included oxygen delivery three times daily, and oxygen saturation three times daily. R8's assessment dated February 11, 2025, included: needs help with oxygen equipment - 1-2 liters as needed (PRN) to keep saturation above 90%. He is able to do this on his own. He will request help if needed. R8's prescriber order dated January 5, 2021,	01970		

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HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

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01970	Continued From page 83 included: - oxygen via nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) 1-2 liter per minute to keep saturation greater than 90%, use oxygen PRN. On February 13, 2025, at 8:09 a.m., the surveyor observed unlicensed personnel (ULP)-G enter R8's room and inform R8 of breakfast. R8 stood from the recliner he had been seated in. The surveyor observed a NC on the arm of R8's recliner. ULP-G turned off the oxygen concentrator, and commented, "he (R8) always leaves it (oxygen concentrator) on." R8's record did not include an annual order for oxygen. On February 13, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-C stated she found a prescriber's order for R8 which noted oxygen delivery (use), but CNS-C stated she was not able to find an annual order for R8's oxygen. The licensee's Medication & Treatment Orders-Renewal policy dated November 29, 2021, noted residents who receive medication management services by the licensee will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment/therapy orders will be updated with a resident's authorized prescriber following hospitalization, if any changes have occurred. Treatment orders must be renewed at least every 12 months or more frequently as required. signed medication and treatment order renewals would be placed in the resident's record. No further information was provided.	01970		

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01970	Continued From page 84 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2024, during a tour of the facility with clinical nurse supervisor (CNS)-C at 10:31 a.m., the surveyor observed a door near the main entrance and commons area with signage that noted, "please keep door shut at all times," and "oxygen."	02310		

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HOME AND COMFORT, INC. OF GRAND RAPID	500 POWELL AVENUE COLERAINE, MN 55722

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02310	Continued From page 85 The door was unsecured, and the room contained: - four tall oxygen tanks secured - 12 small oxygen tanks secured - two tall oxygen tanks unsecured. Directly after the above observation, CNS-C stated all oxygen tanks needed to be secured, and CNS-C secured the two tall unsecured oxygen tanks. CNS-C stated "it wasn't like this, it happened yesterday." CNS-C said there were no other oxygen tanks at the facility. The licensee's Oxygen policy dated November 29, 2021, noted oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	02320		

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02320	Continued From page 86 and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on November 4, 2017, to provide direct care services under the Assisted Living Facility license. R4 On February 10, 2025, at 12:30 p.m., the surveyor observed ULP-B remove hydrocodone APAP 5/325 mg for R4 from a locked narcotic box. ULP-B documented the medication as administered. On February 10, 2025, at 12:33 p.m., ULP-B took the medication cup to R4's room and administered the medication. ULP-B talked to R4 about not eating much and offered to remove the plate of food R4 had been eating. ULP-B asked R4 if she had a bowel movement.	02320		

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02320	Continued From page 87 On February 10, 2025, at 12:35 p.m., ULP-B emptied R4's plate into the trash can located in the kitchen and went to the medication preparation area. ULP-B reviewed R4's MAR to see if there was another as desired or as needed medication (PRN) that could be given to R4 as R4 had not had a bowel movement. On February 10, 2025, at 12:39 p.m., ULP-B stated she should have waited to document R4's hydrocodone as administered after R4 took the medication. ULP-B added she knew R4 would take the medication. "In all reality I should have waited to document the medication as administered," stated ULP-B. R7 On February 10, 2025, at 12:41 p.m., the surveyor observed ULP-B review R7's MAR and prepare R7's 1:30 p.m. medication, gabapentin. ULP-B took the medication cup to R7 who was seated at the dining room table. ULP-B gave R7 the medication cup and picked up a cup of tea positioned near R7 with a straw. R7 took the medication whole and drank tea from the straw. Directly after the above observation, ULP-B stated she documented R7's medication as administered prior to its administration. ULP-B added, "I normally do put it in (document administered, when prepared) but I suppose you should not document until the medication was administrated." On February 11, 2025, at 9:12 a.m., clinical nurse supervisor (CNS)-C stated ULPs were to document medication as administered after medications were administered, not prior to medication administration.	02320		

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02320	Continued From page 88 The licensee's Medication & Treatment-Administration & Delegation policy dated November 29, 2021, noted when administration of medication or treatment/therapy was delegated or assigned to unlicensed personnel, the license would ensure that the registered nurse had: instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures The RN must instruct the ULP on the following medication administration tasks before delegating the task to them: - the complete procedure of checking a resident's medications administration record (MAR) - the preparation of medications for administration - the administration of the medication to the resident - the documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medication, or the reason for not assisting with mediation administration as ordered, and the initials of the nurse of authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/10/25*
Time: 11:28:50
Report: 7939251026

Food and Beverage Establishment Inspection Report

Location:
Home And Comfort Inc
500 Powell Avenue
Coleraine, MN55722
Itasca County, 31

Establishment Info:
ID #: 0039403
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182450012
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: CHICKEN
Temperature: 198 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: SOUP
Temperature: 39 Degrees Fahrenheit - Location: 2 DOOR RIDGE
Violation Issued: No

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

DISCUSSION
SOUP FREEZING AND RE-HEATING PROCESS
GLOVE USE AND HAND WASHING
EMPLYEE ILLNESS

Type: Full
Date: *02/10/25*
Time: 11:28:50
Report: 7939251026
Home And Comfort Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251026 of 02/10/25.

Certified Food Protection Manager:_____

Certification Number: FM111816 Expires: 07/13/25

Inspection report reviewed with person in charge and left on site.

Signed:_____
REBECCA BURT
OWNER.CFPM

Signed:_____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us