DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

May 23, 2023

Licensee
Augustana Apartments Of Mpls
1509 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30133015

Dear Licensee:

Please note: This notice amends the previous notice dated March 12, 2023. Specifically, the original survey date and the date of the follow-up survey have been amended to reflect the accurate dates.

On May 4, 2023, the Minnesota Department of Health completed a follow-up survey of your survey to determine if orders from the February 3, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 12, 2023

Licensee
Augustana Apartments of Mpls
1509 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30133015

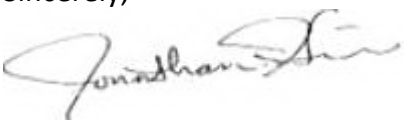
Dear Licensee:

On May 8, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 15, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

Electronically Delivered

March 7, 2023

Licensee
Augustana Apartments of Minneapolis
1509 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30133015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30133015-0 On January 30 through February 3, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 311 active residents; 90 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide adequate staffing to meet the needs of one of six residents (R2) which resulted in a mental health crisis. Further, the licensee failed to provide a staffing plan with required documentation of evaluation at least twice per year. This had the potential to affect all residents and staff at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 had diagnoses of generalized anxiety disorder, major depressive disorder, type 2 diabetes, obstructive sleep apnea and obesity. R2's service agreement dated March 29, 2022, indicated R2 received services including assistance with medication management. A Medication Incident Report Form, dated January 3, 2023, was completed by regional director of operations (RDO)-F which indicated two staff members did not show up for work on the morning of January 2, 2023, causing R2 to miss his 8:00 a.m. and 12:00 p.m. medications. The report indicated R2 was upset, accessed the locked medication box on his own and contacted the pharmacy for instructions on taking his medications independently. The report indicated the actions taken after the event were to replace the staffing position with the regional director of clinical services (RDCS)-L to ensure adequate staffing and the registered nurse (RN)-O was terminated. The report indicated a Minnesota Adult Abuse Reporting Center (MAARC) report was made given the resident's mental health crisis in response to the incident. An Internal Investigation of Incident form, signed by RDO-F on January 4, 2023, and by RDCS-L on January 5, 2023, indicated R2 did not receive	0 470		

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0 470	Continued From page 3 his scheduled medications at 8:00 a.m. and 12:00 p.m. on January 2, 2023, which caused a mental health crisis where R2 presented with suicidal ideation and contacted the suicide crisis line for intervention. The investigation form indicated RDCS-L instructed RN-O to report to work on January 2, 2023, because two staff members did not report to work. The investigation form further indicated RN-O stated residents' medications were overdue and outside of the scheduled time frame to administer so she did not administer the medications. The investigation form further indicated R2's 8:00 p.m. medications were administered and R2 self-administered his 8:00 a.m. and 12:00 p.m. medications. The investigation concluded, "there was not proper staffing and [RN-O] was to go in and help but did not complete their task. Determined [RN-O] unable to properly manage her team and safely care for residents." On January 30, 2023, at 2:22 p.m., unlicensed personnel (ULP)-E stated it was hard to cover the shifts when staff called in, and they just had to "work short". ULP-E further stated staff calling in made it harder for the staff, and they were unable to care for the residents as well. ULP-E further stated caregivers were not always able to get laundry done on time due to staffing shortages. ULP-E further stated a resident was incontinent of bowel the previous week and the soiled laundry was not washed for several days because caregivers were too busy and the laundry facilities were on a different floor and inconvenient to access. On January 30, 2023, at 3:00 p.m., ULP-N stated housekeeping duties did not always get done because they were short-staffed and there was only one housekeeping staff for all four buildings	0 470		

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0 470	Continued From page 4 in the facility. On January 31, 2023, at 7:19 a.m., R2 stated there had been a history of not receiving his medications on time. R2 stated his medications were kept in a locked medication box in his apartment and he required a staff member to open the medication box and administer his medications. R2 stated that on January 2, 2023, his morning medication administration was overdue so he called staff to ask when they would be coming to administer his medication, and was told someone would be up shortly to administer his medications. R2 stated he waited for over an hour after the phone call and decided to go and look for a staff member to help him. R2 stated he encountered an unidentified ULP who told him there was no one to give him his medication due to staff members not showing up for their shift. R2 stated he became very anxious and had a mental health crisis where he wanted to take his own life. R2 stated he called the suicide crisis line and they were able to calm him down and talk him out of harming himself. R2 stated he kept calling the aide office to try and get someone to help him administer his medication, stating, "this went on for hours". R2 stated after no one arrived to administer his morning and afternoon medication he decided to use a pair of pliers to break open the locked medication box and called the pharmacy to get direction on which medications he should take. On January 31, 2023, at 7:27 a.m., ULP-I stated she was currently floating between buildings to assist with resident cares. ULP-I stated she would assist with 2-person cares and transfers. ULP-I further stated they were often working short-staffed, and then she would be asked to fill in.	0 470		

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0 470	Continued From page 5 -at 8:22 a.m., during a medication administration observation, ULP-I stated she was also responsible for orientation of new staff that day. On February 1, 2023, at 10:26 a.m., RDO-F stated R2 told her he had broken into his medication box and self-administered his medication with the assistance of the pharmacy. RDO-F stated they determined the incident was due to two staff members not reporting for their shift on the morning of January 2, 2023. RDO-F stated on a regular day four ULPs worked in the "care suites" of the facility while two ULPs worked in the remaining apartments, or "non-care suites," where R2 resided. STAFFING PLAN The facility staffing plan provided was undated and had spaces for the staffing plan review date, and who completed the review, which were blank. The staffing plan lacked staffing metrics used to determine appropriate staffing levels and evidence the staffing plan had been reviewed twice per year. On February 1, 2023, at 12:52 p.m., RDO-F stated there was no further information for the staffing plan provided. RDO-F was unable to say when the plan was developed or when it was last reviewed. The licensee's Direct Care Staff Plan and Daily Staff Posting policy, dated July 13, 2021, and indicated, "The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year." Further, "A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two." Further, the [licensee]	0 470		

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0 470	Continued From page 6 Direct-Care Staffing plan, which was undated, indicated, "The staffing plan will be reviewed, at a minimum, two times each year. The review will be completed at a minimum during quality management meetings." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 7 Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated January 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene (HH) for 3 of 4 staff (unlicensed personnel (ULP)-D, ULP-E, and ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 8 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H was hired November 2, 2022, and provided direct care services for residents. On January 31, 2023, at 7:43 a.m., during a continuous observation of cares, ULP-H, wearing gloves, washed R4's face and perineal area with a washcloth and soap and water. ULP-H then rinsed the washcloth in the basin of soapy water and cleansed the site of R4's suprapubic urinary catheter (a tube inserted through the abdomen into the bladder to drain urine). Without removing the soiled gloves and performing HH, ULP-H then retrieved a tube of mupiricin (antibiotic) ointment from R4's nightstand, removed the cap, applied the ointment to R4's catheter site with a gloved finger, and applied a clean, split-gauze bandage to the site, taping it into place. Without removing the soiled gloves and performing HH, ULP-H then took her portable electronic device out of her pocket and set it aside. ULP-H then wheeled R4's power wheelchair into the bedroom room using the joystick power control with gloved hand. ULP-H assisted ULP-I to roll R4 to his right side, while ULP-I washed R4's back and applied lotion. ULP-H and ULP-I then assisted R4 with dressing, and positioned the mechanical lift sling under R4. While ULP-I operated the mechanical lift, ULP-H guided R4 into the wheelchair. Without removing the soiled gloves and performing HH, ULP-H	0 510		

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0 510	Continued From page 9 applied a splint to R4's right wrist. ULP-H straightened R4's bed, dumped the basin of soapy water, removed only the right glove, checked her electronic device with the ungloved right hand, then dumped and rinsed a second basin of water. Without performing HH, ULP-H donned a clean glove to right hand, and rinsed R4's urinary catheter tubing and bag and a plastic urinal. ULP-H removed the soiled gloves, accessed her electronic device, exited the room, and entered a staff break area where she performed HH with soap and water appropriately for 16 seconds. On January 31, 2023, at 8:15 a.m., ULP-H stated she had infection control training when hired. ULP-H stated she would change gloves after cleaning a resident if they had a bowel movement. ULP-H stated she did not change gloves after cleaning R4's perineal area, prior to applying the topical antibiotic to R4's catheter site. ULP-H further stated she was not aware she should do so. ULP-H indicated the portable electronic devices used by the ULPs were cleaned at the beginning of each shift using disinfectant wipes, and after use if they provided cares for a resident who was on infection control precautions. ULP-I ULP-I was hired May 1, 2008, and provided direct care services for residents. On January 31, 2023, at approximately 8:22 a.m., ULP-I administered medications to R4. With gloved hands, ULP-I accessed R4's electronic medication administration record (eMAR) using a portable electronic device, and prepared medications for R4. ULP-I, wearing gloves, administered nasal spray to R4, then spoon-fed	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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0 510	Continued From page 10 R4 oral medications, two pills at a time, providing water after each spoonful. ULP-I removed her gloves, picked up empty medication cards, and two electronic devices, then exited R4's room. HH was not observed at this time. ULP-I answered a call on an electronic device, then delivered the empty medication cards to the nursing office. ULP-I then met another caregiver, touched the screen to sign out of one electronic device, and handed it to the caregiver. ULP-I answered a call on another electronic device, then proceeded to the elevator, pushed the down button, entered the elevator, pushing the button "GL", and stated she needed to provide orientation to new staff. ULP-I answered calls on her electronic device two more times, then exited the elevator, and proceeded toward a lobby area where she greeted two new employees by shaking their hands. No HH or cleaning of the electronic device was observed. On January 31, 2023, at 8:40 a.m., ULP-I stated employees have annual training including infection control training. ULP-I stated she observed new employees for HH, and HH should be completed when entering or exiting a resident room and before and after wearing gloves. ULP-I stated she did not perform HH after removing gloves and exiting R4's room, but stated normally that would be her process. ULP-I stated the electronic devices were cleaned after every shift, but were not cleaned between uses in a residents rooms. ULP-E On January 31, 2023, at 8:46 a.m., during a treatment and medication administration observation, ULP-E entered R3's room, and without performing hand hygiene, donned gloves. With a gloved finger, ULP-E accessed R3's eMAR using a portable electronic device. ULP-E	0 510		

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0 510	Continued From page 11	0 510		

checked R3's blood pressure (BP), then accessed R3's medication box, retrieved blood glucose (BG) testing supplies, and proceeded to test R3's BG level. ULP-E removed gloves, then, without performing HH, donned clean gloves and prepared R3's medications, popping the medications out from the medication cards and comparing them to the eMAR on her electronic device. ULP-E administered medications to R3 with water. With a gloved hand, ULP-E accessed the electronic device and documented the BP, BG, and medication administration. ULP-E then removed and discarded the gloves.
-at 8:52 a.m., ULP-E exited R3's room, carrying empty medication cards from R3's medication box. ULP-E, without performing hand hygiene, knocked, and entered R9's room, across the hall. ULP-E, still holding R3's empty medication cards, visited with R9 briefly, then exited, closing the door. ULP-E proceeded in elevator to a 4th floor nursing area to deliver the empty medication cards to the nurse. No HH was observed at this time. The surveyor prompted ULP-E, who then appropriately performed HH using soap and water for 15 seconds.

On January 31, 2023, at approximately 9:00 a.m., ULP-H stated nurses perform HH audits and test staff "every now and then," but was unable to recall when it was last done.

On January 31, 2023, at 9:11 a.m., registered nurse (RN)-B stated hand hygiene supplies were not provided in resident rooms, and pocket-sized hand sanitizer was not provided to caregivers. RN-B further stated there were many supply shortage issues and indicated that was possibly why the supplies were not available.

On February 1, 2023, at 3:28 p.m., regional

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 510	Continued From page 12 director of operations (RDO)-F stated the licensee did not supply paper towels or soap in resident apartments, but did provide both in the staff break area. RDO-F further stated the licensee provided personal hand sanitizer to staff as well as in dispenser stands around the common areas of the facility. The CDC guidance titled, Hand Hygiene in Healthcare Settings, dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The licensee's Hand Washing/Hand Hygiene policy, last reviewed October 4, 2021, indicated, "Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated. If hand hygiene is with an alcohol-based hand rub it must containing 60 - 95% ethanol or isopropanol. a. Before and after direct contact with a client; b. If moving from a contaminated-body site to a clean-body site during client care; c. After removing gloves or gowns; d. Before and after eating or handling food; e. Before or after handling medication (either method); f. After personal use of the toilet; g. After blowing or wiping nose; and	0 510		

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0 510	Continued From page 13 h. When hands are visibly soiled." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a	0 550		

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0 550	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 30, 2023, at 11:39 a.m., during the facility tour with licensed assisted living director (LALD)-C, required postings for the grievance procedure, grievance contact information, regional Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center could not be located or observed. Commons areas and entrances observed included: - 1510 building (address number), main entrance near the offices; - a large bulletin board in a commons area near the 1510 building main entrance; - main dining area; - 1020 building entrance and commons area; - 1509 building entrance and commons area; and - 1425 building commons area. During the facility tour on January 30, 2023, at 11:39 a.m., LALD-C stated she was new to the facility and did not know the location of the grievance and ombudsman postings. LALD-C stated she was aware they were required postings and needed to assess the facility and post the required information. No further information was provided.	0 550		

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0 550	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for four of six residents (R1, R2, R5, and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 630		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 630	Continued From page 16 R1 R1's service plan, dated May, 18, 2022, indicated R1 received services including assistance with medication management, meals, housekeeping and laundry. R1's comprehensive RN assessment, dated May 18, 2022, indicated R1 required use of a 4-wheeled walker (4ww). R1's IAPP, updated August 26, 2022, indicated R1 was vulnerable to abuse but lacked specific measures and interventions to minimize the risk of abuse. The IAPP indicated to refer to the resident's plan of care for interventions. A plan of care was not provided. R2 R2's service plan, dated March 29, 2022, indicated R2 received services including assistance with medication management, meals, housekeeping and laundry. R2's comprehensive RN assessment, dated May 5, 2022, indicated R2 required use of a 4ww and total dependence for housekeeping and laundry. R2's IAPP, dated May 5, 2022, indicated R2 was not vulnerable to abuse despite being a vulnerable adult with vulnerabilities identified in the May 5, 2022, comprehensive RN assessment and March 29, 2022, service plan. R2's IAPP, updated January 5, 2023, indicated R2 was vulnerable to abuse but lacked specific measures and interventions to minimize the risk of abuse. R5	0 630		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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0 630	Continued From page 17 R5's service plan, dated March 28, 2019, indicated R5 received services including assistance with medication set-up, and housekeeping. R5's record included a comprehensive nursing assessment dated September 16, 2022. The assessment indicated R5 had a diagnosis of mental illness or cognitive impairment, and used a walker. The assessment further indicated R5 needed "minor assist" with "self-preservation", and transportation. The assessment further indicated R5 needed assistance with finances, housekeeping, and food preparation. R5's IAPP, dated September 16, 2022, indicated R5 was not vulnerable to abuse by others. R5's IAPP further indicated R5 had vulnerabilities including: mental illness, chronic pain, history of alcohol abuse, and financial exploitation. R5's IAPP lacked specific interventions to the identified vulnerabilities. The IAPP indicated to refer to resident's plan of care for interventions, but a plan of care was not available. R6 R6's service plan, dated July 26, 2021, indicated R6 received services including assistance with blood glucose management, medication management, and housekeeping. R6's record included a comprehensive nursing assessment dated January 28, 2023. The assessment indicated R6 had cataracts (progressive clouding of the lens of the eye that can result in vision loss), used a 4ww, had delusions and hallucinations, difficulty in communication, and needed assistance with medication management and pain management.	0 630		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 630	Continued From page 18 R6's IAPP, dated August 22, 2022, indicated R6 was not vulnerable to abuse by others. R6's IAPP further indicated R6 had vulnerabilities including: mental illness, and chronic pain. R6's IAPP lacked specific interventions to the identified vulnerabilities. The IAPP indicated to refer to resident's plan of care for interventions, but a plan of care was not available. On January 31, 2023, at 1:03 p.m., RN-B stated resident IAPPs did not address all interventions to prevent abuse. RN-B stated the interventions and measures to be taken were typically addressed on service plans. RN-B stated they did not have a plan of care or any other documentation where additional interventions would be found. The licensee's Comprehensive Assessment, monitoring and reassessment-AL policy, dates August 1, 2019, indicated the nursing assessment would include an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the client poses a risk to other vulnerable adults. The RN will use this assessment as the basis for the client's individual abuse prevention plan that identifies the specific measures to be taken to minimize the risk of maltreatment to the client or to other vulnerable adults. The policy further indicated, "Based on the RN's assessment of the resident's needs and vulnerabilities, the RN will develop a comprehensive Service Plan and Plan of Care that addresses the resident's needs and includes interventions necessary to reduce the resident's risk of maltreatment or to reduce the risk that the resident may pose to other vulnerable adults." No further information provided.	0 630		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 630	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number in common areas and near telephones provided by the assisted living facility. In addition, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility common areas. This had the potential to 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	0 640		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 640	Continued From page 20 the residents). The findings include: On January 30, 2023, at 11:39 a.m., during a facility tour with licensed assisted living director (LALD)-C, house phones and common areas were observed to lack required 911 emergency phone number postings at three observed house phones and in common areas. Common areas and entrances observed were as follows: - 1510 building, main entrance near the offices; - a large bulletin board in a commons area near the 1510 building main entrance; - main dining area; - 1020 building entrance and commons area; - 1509 building entrance, sitting room and commons area; and - 1425 building lobby/mail area, and commons area. During the facility tour on January 30, 2023, at 11:39 a.m., LALD-C stated she was new to the facility but was aware of the required postings for 911 emergency phone number and MAARC reporting information. She stated she needed to assess the facility and post missing required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 680	Continued From page 21 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. Further, the EP plan was not prominently displayed and available for residents, staff and visitors. This had the potential to effect all residents, staff and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 680	Continued From page 22 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 included: On January 30, 2023, at 11:39 a.m., during a facility tour with licensed assisted living director (LALD)-C, the EP plan was not displayed prominently nor available in or near any of the entrances or commons areas. On January 30, 2023, at 11:39 a.m., LALD-C stated she did not know where the EP plan was posted or on display. On January 30, 2023, at 2:09 p.m., regional director of operations (RDO)-F provided the facility EP plan in two separate binders. RDO-F stated the first binder entitled Safety Policies and Procedures was available out on the unit. RDO-F stated the second binder entitled All Hazards Plan was kept in the aide office. Upon review the EP plan lacked the following: - annual reviews of the both binders; - the Safety Policies and Procedures binder indicated it had been last revised in July and August, 2020, and provided no annual review date; and - the All Hazards Plan binder did not indicate a date it had been created or when it was last review, page three had a blank annual review date form. On January 30, 2023, at 2:50 p.m., RDO-F stated she was aware of the EP plan requirements and was in the process of updating it but was unsure when it was last reviewed. RDO-F stated the Safety Policies and Procedures was available only in administrative offices and was available	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 23 for residents, staff, or visitors. RDO-F stated the All Hazards Plan was kept in the aide office along with a few other offices. The licensee's Emergency Preparedness Program/Plan policy, dated July 1, 2022, indicated, "The Emergency Preparedness plan will be reviewed by the leadership team and other designated individuals annually or as major changes occur. Copies of this plan will be kept in designated areas inside and outside of the facility for immediate access by the administrator or their designee/s." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 24 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for 2 of 6 residents (R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	0 730		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 730	Continued From page 25 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 and R6's medical records lacked documentation of services received. R3's service plan, dated September 6, 2022, indicated R3 received services including assistance with the following: -bathing (twice weekly), -morning and evening cares (daily); -transfer assistance (up to five times per day); -toileting assistance (up to 12 times per day); -housekeeping (once weekly); and -laundry (two loads weekly). R3's service record for January 1-30, 2023 lacked the following documentation: -2 of 4 services for personal laundry; and -2 of 4 services for housekeeping. R6's service plan, dated July 26, 2021, indicated R6 received services including assistance with housekeeping (once weekly). R6's service record for January 1-30, 2023 lacked the following documentation: -1 of 4 services for housekeeping. On January 30, 2023, at 2:36 p.m., unlicensed personnel (ULP)-E stated caregivers were not always able to get laundry done on time due to staffing shortages. ULP-E stated R3 was incontinent of bowel the previous week and the soiled laundry was not washed because caregivers were too busy and the laundry facilities	0 730		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 730	Continued From page 26 were on a different floor and inconvenient to access. On January 30, 2023, at 3:00 p.m., ULP-N stated housekeeping duties were not always completed because they were short-staffed and there was only one housekeeping staff for the facility. On January 31, 2023, at 10:24 a.m., regional director of clinical services (RDCS)-D stated blank spots in the service record indicated the service was not documented. RDCS-D agreed some documentation appeared incomplete in resident records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 780	Continued From page 27 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms and failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 1, 2023, at approximately 10:30 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-C, Director of Safety and Quality Support (DSQS)-M, and Director of Maintenance (DM)-G. During the facility tour, survey staff observed the following: In all resident units in building 1510, the required	0 780		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 780	Continued From page 28 smoke alarms were not provided in any of the sleeping rooms and any hallway outside of the bedroom. During the interview, DM-G confirmed the deficient conditions consistent in every resident unit in the entire building 1510. DM-G also stated that the facility planned to sell building 1510, only fixing or maintaining it when a resident from the occupied unit requested. The deficient conditions were visually verified by LALD-C, DSQS-M, and DM-G accompanying the tour. In two-bedroom units, the required smoke alarms were not installed in the immediate vicinity of sleeping rooms. The facility installed one smoke alarm in the living room but did not install one in the hallway outside of the bedroom. During the interview, DM-G confirmed the deficient conditions consistent in every two-bedroom resident unit in building 1509, building 1510, building 1020, and building 1425. The deficient conditions were visually verified by LALD-C, DSQS-M, and DM-G accompanying the tour. In resident unit 1231 in the building, the required smoke alarms were not provided in both bedrooms and the hall outside of the bedrooms. During the interview, DM-G stated that the resident had a burnt scent and that somebody had removed those smoke alarms. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 29 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 1, 2023, at approximately 10:30 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-C, Director of Safety and Quality Support (DSQS)-M, and Director of Maintenance (DM)-G. During the facility tour, survey staff observed the following: BUILDING 1425 In the storage room within the meeting room on	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 30 the 12th floor, it was observed that there appeared to be mold or a similar black substance on the ceiling exhaust fan, and the sprinkler head was covered with dark-colored dust. In the serving kitchen within the meeting room on the 12th floor, wallpaper was peeled off from the wall at the hall side. In the uni-sex restroom on the 12th floor, the toilet flusher did not work, and the sprinkler head was missing an escutcheon. Elevator lobby on the 12th floor: ceiling paint was peeled and bubbled from water intrusion above. During the interview, DM-G stated he was aware of water intrusion and damages, and he was planning for a roofing inspection in the spring once the snow was gone. In resident unit 651, it was observed the bathroom sprinkler head was covered with thick dust. In the corridor on the 6th floor, it was observed that there was a considerable dark brown stain on the acoustical ceiling tile with evidence of water damage. It was observed that door closers on all observed resident doors had been disabled by removing the closure arm or closure device. All doors observed still had a portion or remnants of the closure device still mounted on the door. DM-G stated that this was consistent with all resident units and other corridor doors throughout the facility. The door closure device was required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes.	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 31 In Resident unit 451, it was observed the wood base was missing and exposing a sharp wood edge from the adjacent corner. In the elevator lobby on the 1st floor, the radiant heater was missing part of the cover assembly and missing end cap exposing sharp metal edges. BUILDING 1509 Door closers on all observed resident doors had been disabled by removing the closure arm or closure device. All doors observed still had a portion or remnants of the closure device still mounted on the door. During the interview, DM-G stated that this was consistent with all resident and other corridor doors throughout the facility. The door closure device was required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. In the corridor on many floors, the wire mold raceway was installed on the wall and ceiling transition. The wire molds were not secured in many locations and hanging low over the resident's door . In resident unit 322, it was observed that four glue mouse traps were laid in front of the unit door on the corridor side, and a live mouse was trapped on it. In resident unit 313, it was observed the wood base was missing and exposing a sharp wood edge from the adjacent corner. It was also observed that the carpet was stained with possible urine stains in the living room, and the floor, wall, and fixtures were stained with a dark	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 32 substance in the bathroom. In the elevator lobby on the 2nd floor, the radiant heater was missing part of the cover assembly and missing end cap exposing sharp metal edges. In the men's restroom on ground level, it was observed that the supply air grille was hanging out of the acoustic ceiling. It was also observed that there was a considerable dark brown stain on acoustic ceiling tile. The trash chute door on the ground level by the men's restroom was projected out from the wall and had a gap at the door's perimeter. The trash door was required to be flush with a wall to maintain the fire integrity of the trash chute. In storage locker rooms 1 and 19 in the basement, it was observed that door closers on the door had been disabled by removing the closure arm or closure device. The door closure device was required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. BUILDING 1020 Door closers on all observed resident doors had been disabled by removing the closure arm or closure device. All doors observed still had a portion or remnants of the closure device still mounted on the door. During the interview, DM-G stated that this was consistent with all resident and other corridor doors throughout the facility. The door closure device was required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes.	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 33 The elevator lobby on the 12th floor had a large hole in the gypsum ceiling. During the interview, DM-G stated that there was a pipe leakage above the ceiling. The corridor in front of unit 1242 on the 12th floor had a hole on the gypsum ceiling. During the interview, DM-G stated that there was roofing leakage above the ceiling. In resident unit 1134, there was a considerable dark brown stain on the gypsum ceiling in the bathroom. In resident unit 934, the bathroom exhaust fan was covered with thick dust. In resident unit 841, the bathroom exhaust fan control lever was missing, and it could not operate the fan. The clean linen closet by the elevator on the 8th floor had considerable damage to the sheetrock ceiling and wall, with evidence of water damage. In the corridor on the 6th floor, a wall-mounted light was not working near the egress stair. BUILDING 1510 It was observed that only two or three units were occupied out of approximately 12 units per floor. During the interview, DM-G stated that the facility planned to sell building 1510 and only fix or maintain the building if required. DM-G also stated the facility would not take any new residents to the building, and the facility was not fixing damaged units after residents move. Door closers on all observed resident doors had been disabled by removing the closure arm or	0 800		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 34	0 800		

closure device. All doors observed still had a portion or remnants of the closure device still mounted on the door. During the interview, DM-G stated that this was consistent with all resident and other corridor doors throughout the facility. The door closure device was required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes.

In resident unit 1208, kitchen equipment was missing and removed from the cabinet. During the interview, DM-G stated that that equipment had been relocated to fix other units, and they were not adding new kitchen equipment since they were not taking any new residents.

In resident unit 1201, the kitchen ceiling-mounted light did not work.

Resident unit 1103, was observed to be vacant, and the room was heavily damaged. Inside the unit, the carpet was stained, the wall had holes, the casework was broken, and the room was full of trash. During the interview, DM-G stated that the resident had just moved out, leaving those damages, and the facility was not planning to repair the damage.

In resident unit 1008, the bathroom exhaust fan was closed, and the fan was not working.

In resident unit 808, the bathroom exhaust fan was covered with thick dust and considerable damage to the sheetrock ceiling was observed, with evidence of water damage.

In the bathroom of resident unit 602, dark brown stains were on the sheetrock ceiling and wall, with evidence of water damage in the bathroom. Also,

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 35 the bathroom exhaust fan was covered with thick dust. On the stair on the 4th floor, the wall had a large hole in the sheetrock. This wall was part of a fire barrier and required to maintain fire resistance integrity. In the elevator lobby and corridor on the 3rd floor, 2nd floor, and 1st floor, the wallpaper was peeled and was hanging loose from the wall. During the interview, DM-G stated that the wallpaper was removed from water damage from a pipe leakage above the ceiling. In resident unit 108, the bathroom exhaust fan was closed, and the fan was not working. DM-G visually verified the deficient findings at the time of discovery. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 810	Continued From page 36 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 810	Continued From page 37 a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on February 1, 2023, at approximately 10:30 a.m., with Licensed Assisted Living Director (LALD)-C, Director of Safety and Quality Support (DSQS)-M, and Director of Maintenance (DM)-G on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Review of the Comprehensive Fire Plan provided by DSQS-M indicated that all staff received emergency and disaster training in orientation and annually, not twice per year after initial hire as required by statute. During the interview, DSQS-M stated that the facility provided only one fire safety training on November 2, 2022, and confirmed this deficiency. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=E	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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0 970	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for 3 of 6 residents (R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3, R5, and R6's Assisted Living contracts, signed September 8, 2022, December 6, 2021, and September 6, 2022, respectively, each included the following language indicating a waiver of liability on page 14: 22. INDEMNIFICATION "As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly	0 970		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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0 970	Continued From page 39 or in part by, an act or omission of Resident or Resident's guests or agents." 24. LIABILITY: "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises." On February 1, 2023, at 12:52 p.m., regional director of operations (RDO)-F stated there was an addendum to the contract retracting the waiver language provided to the residents or their representatives. RDO-F stated she was unable to locate the signed addendum for R5 and if others were not in the record, it was likely the document was not signed and returned. RDO-F stated there was no other documentation to show the addendum had been provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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01620	Continued From page 40	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for one of six residents (R2). The licensee also failed to ensure the RN conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, upon change of condition, and not to exceed 90 calendar days from the last	01620		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01620	Continued From page 41 assessment date for six of six residents (R1, R2, R3, R4, R5, R6). 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: R2-CHANGE OF CONDITION R2 was admitted May 2, 2022, and had diagnoses of generalized anxiety disorder and major depressive disorder. R2's service plan, dated March 29, 2022, indicated R2 received services including medication management, housekeeping and laundry. R2's January 2023, medication administration record (MAR) indicated R2's medications included the following: -amphetamine dextroamphetamine (Adderall, for attention deficit/hyperactive disorder) tablet 30 mg; give 15 mg by mouth twice daily; -bupropion (a psychotropic medication) extended release (ER) 300 mg tablet; give 300 mg by mouth once daily; -buspirone (for generalized anxiety disorder) tablet 15 mg; give one tab by mouth three times daily;and -Sertraline (for major depressive disorder) tablet, two tablets (200 mg) by mouth once daily; R2's individual abuse prevention plan (IAPP),	01620		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01620	Continued From page 42 dated January 5, 2023, indicated R2 was vulnerable due to mental illness. A Medication Incident Report Form dated January 3, 2023, completed by regional director of operations (RDO)-F indicated two staff members did not show up for work on the morning of January 2, 2023, causing R2 to miss his 8:00 a.m. and 12:00 p.m. medications. The report indicated R2 was upset and accessed the medication box and took his medications independently. The report indicated a Minnesota Adult Abuse Reporting Center (MAARC) report was made due to a mental health crisis following the incident. An Internal Investigation of Incident form, signed by RDO-F on January 4, 2023, and by regional director of clinical services (RDCS)-L on January 5, 2023, indicated R2 did not receive his scheduled medications at 8:00 a.m. and 12:00 p.m. on January 2, 2023, which caused a mental health crisis where R2 indicated plans to end his life. The investigation revealed R2 contacted a suicide hotline that intervened. R2's record lacked a change of condition assessment following the missed medication administration and mental health crisis incident. R2's most recent assessment prior to the incident was completed on August 16, 2022. R2's record included a progress note entered January 20, 2023, at 11:28 a.m., by RN-B. The progress note indicated an unlicensed personnel (ULP) went to R2's apartment on January 20, 2023, at 8:55 a.m., to administer R2's medications but R2 was not there. The progress note further indicated the ULP called R2 on January 20, 2023, at 9:03 a.m., and R2 indicated	01620		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01620	Continued From page 43	01620		

he told them he needed medications administered prior to 9:00 a.m., before he was picked up from the facility. The progress note further indicated as a result, R2 self-administered his morning medication and also packed his own 12:00 p.m., medications and took them with him out of the facility.

On February 1, 2023, at 10:26 a.m. RDCS-D stated a change of condition comprehensive nursing assessment should have been completed following the January 2, 2023, incident.

R2-14-DAY/90-DAY REASSESSMENT
R2's record included a comprehensive RN assessment, dated May 27, 2022, greater than 14-days after start of services.

R2's record included a comprehensive RN assessment, dated August 16, 2022, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after).

R1
R1's service plan, dated May 18, 2022, indicated R1 received services including assistance with medication management, housekeeping and laundry.

R1's record included a comprehensive nursing assessments dated May 18, 2022, May 31, 2022, and August 26, 2022, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after).

R3
R3's service plan, dated September 6, 2022, indicated R3 received services including assistance with bathing, toileting, transfers, laundry, housekeeping, blood glucose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01620	Continued From page 44 management, and medication management. R3's record included a comprehensive nursing assessment dated August 22, 2022, and a subsequent change in condition assessment dated September 6, 2022, but lacked any additional assessments as of the date of the survey (greater than 90 days after). R4 R4's service plan, dated February 1, 2023, indicated R4 received services including assistance with bathing, transfers, laundry, housekeeping, catheter care and medication management. R4's record included a comprehensive nursing assessment dated, June 24, 2022, and September 6, 2022, respectively, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after). R5 R5's service plan, dated March 28, 2019, indicated R5 received services including assistance with medication set-up, and housekeeping. R5's record included a comprehensive nursing assessment dated September 16, 2022, but lacked any subsequent assessments as of the date of the survey (greater than 90 days after). R6 R6's service plan, dated July 26, 2021, indicated R6 received services including assistance with blood glucose management, medication management, and housekeeping. R6's record included a comprehensive nursing	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01620	Continued From page 45 assessment dated August 22, 2022, and a subsequent assessment dated January 28, 2023, greater than 90 days after the previous assessment. On January 30, 2023, at 10:53 a.m., during the entrance conference, registered nurse (RN)-A stated assessments should be completed upon admission, at 14 days, at least every 90 days and upon a change of condition. RN-A stated some resident assessments had not been completed in a timely manner due to recent clinical administrative staff turnover. On January 31, 2023, at 11:52 a.m., RDCS-D stated there were no more recent assessments completed for R5, and the nursing assessment was overdue. The licensee's Comprehensive Assessment, Monitoring and Reassessment-AL policy, dated August 1, 2019, indicated: "- The assessment will be the basis for the Service Plan that the RN will recommend to the client and the basis for the Plan of Care that staff will follow when implementing the resident's services. Monitoring and reassessment of the client will be conducted in the resident's home within 14 days after initiation of services. Ongoing reassessment and monitoring will occur as needed based on the resident's needs and at a frequency not to exceed 90 days from the date of the last assessment. The assessment may be conducted in person or telephonically depending on the individual resident's needs. The Service Plan and Plan of Care will be reviewed and updated based on the needs of the resident; - An assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the client poses a risk to other	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 46 vulnerable adults. The RN will use this assessment as the basis for the client's individual abuse prevention plan that identifies the specific measures to be taken to minimize the risk of maltreatment to the client or to other vulnerable adults; - Based on the RN's assessment of the resident's needs and vulnerabilities, the RN will develop a comprehensive Service Plan and Plan of Care that addresses the resident's needs and includes interventions necessary to reduce the resident's risk of maltreatment or to reduce the risk that the resident may pose to other vulnerable adults; and - The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the date of the last assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01730	Continued From page 47 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an admission medication management plan, and updated the plan when there was a change in the resident's medications or medication administration status for one of six residents (R2). This practice resulted in a level two violation (a	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01730	Continued From page 48 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's service plan, dated March 29, 2022, indicated R2 received services including assistance with medication management. R2's record lacked a medication management plan completed upon start of medication management services. R2's medication administration record (MAR) for January, 2023, indicated R2 received assistance with medication administration daily January 1 through January 31, 2023. R2's record lacked signed prescriber orders for the following medications included on the January MAR: - acetaminophen (for pain), one tablet by mouth every six hours as needed; - metformin (blood glucose control) 500 mg extended release, four tablets (2000 mg) by mouth once daily; - oyster shell tablet 500 mg; 1 tablet by mouth daily for supplement; - clonidine patch 0.1 mg/24 hours; apply 1 patch to skin once a week for hypertension; - nystatin powder (for skin irritation) 100,000 units/gram (g); apply to abdominal folds twice daily until irritation resolves; - genteal tears solution moderate; give 1 drop in	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01730	Continued From page 49	01730		

both eyes every day and every 4 hours as needed for dry eyes;
- ibuprofen (for pain) tablet 600 mg; give 1 tablet by mouth every 6-8 hours as needed for pain;
- polyethylene glycol powder 3350; mix 17 g (1 capful to line) in 8 ounces (oz) of liquid and drink daily as needed for constipation; and
- ventolin aerosol inhaler; inhale 1-2 puffs by mouth every 4 hours as needed for wheezing.

A Medication Incident Report Form dated January 3, 2023, completed by regional director of operations (RDO)-F indicated two staff members did not show up for work on the morning of January 2, 2023, causing R2 to miss his 8:00 a.m. and 12:00 p.m. medications. The report indicated R2 was upset and accessed the medication box and took his medications independently. The report indicated a Minnesota Adult Abuse Reporting Center (MAARC) report was made due to a mental health crisis following the incident.

R2's record included a medication management plan created on, January 5, 2023, following the January 2 incident.

R2's record included a progress note entered by RN-B, January 20, 2023. The progress note indicated R2 again broke into his medication box on January 20, 2023, when staff again did not arrive to administer his morning medications. R2's record lacked a medication assessment or updated medication management plan following the incident.

On January 31, 2023, RN-B stated R2's medication administration process had changed on January 30, 2023. RN-B further stated R2 would be self-administering medications after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01730	Continued From page 50 medications were set-up in his room with pill boxes. RN-B stated there should have been an updated medication management plan to address the change. On February 9, 2023, at 3:39 p.m., RN-A stated via email the medication management plan completed on January 5, 2023, was the only one in R2's record. RN-A further stated a medication management plan should be developed upon admission for residents receiving assistance with medication management. The licensee's Medication Management Services-AL policy, dated August 7, 2019, did not address when medication management plans should be developed or updated. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01760	Continued From page 51 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medications were administered according to providers orders for four of six residents (R1, R3, R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). R1's service plan, dated May 18, 2022, indicated R1 received services including assistance with medication management. R1's medication administration record (MAR) for January, 2023 lacked documentation of administration or why the medication was not administered for the following dates: - Trulicity injection (for diabetes) 1.5 milligram (mg)/0.5 milliliters (ml) subcutaneously once weekly; January 6, 13, 20, and 27; - acetaminophen (for pain) tablet 500 mg, take two tablets (1000 mg) by mouth three times daily; January 6 and 9 at 12:00 p.m.; - gabapentin (for nerve pain) capsule 300 mg, take three capsules (900 mg) by mouth three times daily; January 6 and 9 at 12:00 p.m.; - hydroxyzine (for anxiety) tablet 25 mg, take one tablet by mouth three times daily; January 6 and 9 at 12:00 p.m.; and - olanzapine (for anxiety) tablet 2.5 mg, take one	01760		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 52 tablet by mouth twice daily; January 6 and 9 at 12:00 p.m. R3 R3's service plan, dated September 6, 2022, indicated R3 received services including assistance with medication management. R3's MAR for January, 2023 lacked documentation of administration or why the medication was not administered for the following dates: - amlodipine (for blood pressure) 5 mg, two times daily; January 15, 30 at 8:30 a.m., and January 13, 14, 18, 23, 28, 31 at 10:00 p.m.; - aspirin (for pain/blood thinner) 81 mg, chewable, one tablet daily; January 15 and 30 at 8:30 a.m.; - escitalopram (for depression) 20 mg, one tablet daily; January 15, and 30 at 8:30 a.m.; - Fosrenol (phosphorus binder) 500 mg, chewable, three tablets (1500 mg) with meals; January 15, and 30 at 8:30 a.m., January 6, 7, 23, 27, 30, 31 at 11:30 a.m., and January 13, 27, 31 at 5:30 p.m.; - furosemide (diuretic) 40 mg, one tablet, two times daily; January 15, and 30, at 8:30 a.m., and January 6, 7, 23, 27, 30, and 31 at 11:30 a.m.; -lisinopril altissimo(for blood pressure) 40 mg, one tablet, every night at bedtime (qhs); January 13, 18, 23, 28, 31, at 10:00 p.m.; - melatonin (sleep supplement) 3 mg, one tablet qhs; January 13, 14, 18, 23, 28, 31, at 10:00 p.m.; - metoprolol (for blood pressure) 50 mg one tablet qhs; January 13, 14, 18, 23, 28, 31, at 10:00 p.m.; - midodrine hydrochloride (for blood pressure)10 mg, one tablet, one time a day every Monday, Wednesday and Friday, before dialysis; January 25, and 30 at 8:00 a.m.;	01760		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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01760	Continued From page 53 - olanzapine 5 mg, one tablet qhs; January 13, 14, 18, 23, 28, 31, at 10:00 p.m.; - olopatadine (for eye itching, irritation) 0.1% eye drops,0.05 ml, two times daily, instill one drop in both eyes; January 15, and 30 at 8:30 a.m., and January 13, 14, 18, 23, 28, and 31 at 10:00 p.m.; - omeprazole (for stomach acid, gastroesophageal reflux disease) 20 mg, one capsule daily; January 15, and 30 at 8:30 a.m.; - rosuvastatin (for cholesterol) 20 mg, one tablet qhs; January 13, 14, 18, 23, 28, 31, at 10:00 p.m.; - sevelamer carbonate (phosphorus binder) 800 mg, take two tablets (1600 mg) three times daily; January 15, 30, at 8:30 a.m., and January 6, 7, 23, 27, 30 and 31 at 11:30 a.m.; - triphrocap (supplement), one capsule every day; January 15, and 30 at 8:30 a.m.; and - vitamin D3 (supplement) 1000 units (u) (25 micrograms (mcg)) one tablet daily; January 15, and 30 at 8:30 a.m. R4 R4's service plan, dated June 8, 2020, indicated R4 received services including assistance with medication management. R4's MAR for January, 2023, lacked documentation of administration or why the medication was not administered for the following dates: -chlorhexidine gluconate (oral rinse) 0.12% swish and spit, 15 ml ,once daily; January 7, and 9 at 7:00 a.m.; -TheraCran (supplement) 360 mg: one capsule every morning; January 7, 9, and 13 at 7:30 a.m.; -aspirin 81 mg enteric coated one tablet daily; January 7, and 9 at 7:30 a.m.; -cetirizine (antihistamine) 10 mg, one tablet daily; January 7, and 9 at 7:30 a.m.;	01760		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01760	Continued From page 54 -clopidogrel (platelet inhibitor) 75 mg, one tablet daily; January 7, and 9 at 7:30 a.m.; -fluticasone nasal spray 50 mcg, instill one spray in each nostril twice daily; January 7, and 9 at 7:30 a.m.; and January 2, and 19 at 9:00 p.m.; -metoprolol 25 mg, 1/2 tablet (12.5 mg) twice daily; January 7, and 9 at 7:30 a.m.; and January 19 at 9:00 p.m.; -omeprazole 20 mg, one capsule daily; January 7, and 9 at 7:30 a.m.; -oxybutynin (for muscle/bladder spasms) 5 mg, one tablet twice daily; January 7, and 9 at 7:30 a.m.; and January 19 at 9:00 p.m.; -psyllium fiber (fiber laxative) 0.52 grams (gm) one capsule twice daily; January 7, and 9 at 7:30 a.m.; -Tab-A-Vite (supplement), one tablet daily; January 7, and 9 at 7:30 a.m.; and -rosuvastatin 40 mg, one tablet qhs; January 19 at 9:00 p.m. R6 R6's service plan, dated July 26, 2021, indicated R6 received services including assistance with medication management. R6's MAR for January, 2023 lacked documentation of administration or why the medication was not administered for the following dates: - acetaminophen 325 mg two tablets (650 mg) by mouth three times daily; January 13 at 9:30 a.m., January 3, 6, 10, and 13 at 12:00 p.m., January 6 at 10:00 p.m.; - aripiprazole (an antipsychotic) 5 mg one tablet by mouth once daily; January 13 at 9:30 a.m.; - capsaicin cream (for pain) 0.025% apply to soles of feet once daily; January 13, 16, 27 at 9:30 a.m.; - cerovite senior (vitamin supplement) one tablet	01760		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 55	01760		

by mouth once daily; January 13 at 9:30 a.m.;
- fish oil capsule (supplement) 1200 mg one tablet by mouth once daily; January 13 at 9:30 a.m.;
- Jardiance (for diabetes) 10 mg one tablet by mouth once daily; January 13 at 9:30 a.m.;
- Lantus solostar (insulin glargine, a long-acting insulin) 100 u/ml inject 30 u subcutaneously twice daily; January 13 at 9:30 a.m., January 6 at 10:00 p.m.;
- lisinopril 40 mg one tablet by mouth once daily; January 13 at 9:30 a.m.;
- novolog flexpen (insulin aspart, a fast-acting insulin) inject six units subcutaneously before breakfast; January 13 at 9:30 a.m.;
- polyethylene glycol powder (for constipation) mix 17 gm in eight ounces (oz) water and drink daily; January 13 at 9:30 a.m.;
- prednisone 2.5 mg (a steroid) five tablets (12.5 mg) by mouth every morning; January 13 at 9:30 a.m.;
- pregabalin (for neuropathy (nerve pain)) 100 mg one capsule by mouth three times daily; January 13 at 9:30 a.m., January 3, 6, 10, 13 at 12:00 p.m., and January 6 at 10:00 p.m.;
- sodium bicarbonate (for low blood pressure) 650 mg one tablet by mouth twice daily; January 13 at 9:30 a.m., January 6 at 10:00 p.m.;
- vitamin B complex/vitamin C (supplement) one capsule by mouth once daily; January 13 at 9:30 a.m.;
- vitamin D3 25 mcg one tablet by mouth once daily; January 13 at 9:30 a.m.;
- Novolog flexpen inject 12 u subcutaneously once daily at noon before a meal; January 3, 6, 10, 13 at 12:00 p.m.;
- Trulicity inject 0.5 ml (3 mg) subcutaneously once a week; January 3, 17, 31 at 4:30 p.m.;
- allopurinol (for gout) 100 mg one tablet by mouth at bedtime; January 6 at 10:00 p.m.; and

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01760	Continued From page 56 - haloperidol (antipsychotic) 2 mg one tablet by mouth at bedtime; January 6 at 10:00 p.m. On January 31, 2023, at 10:24 a.m., regional director of clinical services (RDCS)-D stated an "X" on the resident's MAR would indicate a medication was not scheduled, a "circle" the medication was refused, a "H" the medication was on hold and if it were blank it indicated the medication was not given and/or not documented. RDCS-D stated blank spaces on the MAR indicated the medication was not documented as given. On February 1, 2023, at 12:52 p.m., RDCS-D stated missing administration documentation had been discussed with registered nurse (RN)-A as an area of concern they were addressing. The licensee's Medication administration policy dated April 29, 2021, indicated "Each resident has the right to participate in their plan of care. If a resident refuses a medication it will be documented as not administered with an explanation of why it was not given. It will be re-offered at a later time if appropriate. If a resident continues to refuse the medication, or demonstrates a pattern of refusals, the provider will be notified." The policy further indicated, "Medication administration is to be documented promptly after administration." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

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AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01820	Continued From page 57 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of six residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on May 22, 2022, and received services including assistance with medication management. R2 diagnoses included generalized anxiety disorder, major depressive disorder, type 2 diabetes, obstructive sleep apnea and obesity. R2's January 2023, medication administration record (MAR) indicated R2 was administered medications including the following: -metformin (blood glucose control) 500 mg extended release, four tablets (2000 mg) by mouth once daily;	01820		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01820	Continued From page 58 -oyster shell (calcium supplement) tablet 500 mg, one tablet by mouth once daily; and -nystatin powder (for skin irritation) 100,000 units/gram (g); apply to abdominal folds twice daily until irritation resolves. The MAR further indicated the following medications were available to be administered, but were not documented as administered in January 2023: -clonidine patch (for high blood pressure) 0.1 mg/24 hours; apply one patch to skin once a week; -acetaminophen (for pain), one tablet by mouth every six hours as needed; -genteal tear solution (artificial tears solution) one drop in both eyes every four hours as needed for dry eyes; -ibuprofen (for pain) tablet 600 mg, one tablet by mouth every eight hours as needed; - polyethylene glycol powder (for constipation) 3350; mix 17 g (one capful to line) in eight ounces (oz) of liquid and drink daily as needed; and - ventolin (albuterol, for asthma) Aerosol Inhaler; inhale one to two puffs by mouth every four hours as needed for wheezing. R2's record lacked signed prescriber orders for the following medications identified above: - acetaminophen; - polyethylene glycol powder; - metformin HCL; - oyster shell tablet; - clonidine patch; - genteal tears solution; - ibuprofen; - nystatin powder; and - ventolin HFA Aerosol Inhaler. On February 1, 2023, at 12:52 p.m., regional director of clinical services (RDCS)-D stated they	01820		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01820	Continued From page 59	01820		

provided all of the prescriptions they could find for R2. RDCS-D further stated they should be available but was unable to locate any additional prescriptions.

R3
R3 was admitted on, July 14,2022, and received services including assistance with medication management.

R3's diagnoses included diabetes, end stage renal disease (ESRD), and amputation of right and left leg, below knees.

R3's record included physician orders signed October 13, 2022, indicating the following:
- Novolog (fast-acting insulin) FlexPen, four units subcutaneously (SQ), two times daily, every Monday, Wednesday and Friday; and
- Novolin 70/30 (intermediate-acting insulin), 18 units SQ every day.

R3's MAR for January 2023 indicated the following medications were not administered as ordered:
- Novolog FlexPen, four units SQ, two times daily, every Monday, Wednesday and Friday: administered January 4 at 8:30 a.m. and 5:30 p.m., and January 5, at 8:30 a.m.; remaining dates indicated hold ("H") or not available ("X") and no additional administration documented during January 2023; and
- Novolin 70/30, 18 units SQ every day at 11:30 a.m.: MAR indicated "H" or "X" and no administration documented during January 2023.

R3's record lacked a signed prescriber order discontinuing the above-listed medications.

R3's MAR for January 2023 indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01820	Continued From page 60 following medications were administered: - Novolog FlexPen, four units SQ, three times daily on Tuesday, Thursday, Saturday, and Sunday: admistered January 4, and 5, 2023, at 8:30 a.m., and January 3, 2023, at 5:30 p.m.; - Novolog FlexPen, inject SQ, daily after a meal per sliding scale: administered January 6-12, 2023, at 8:30 a.m., January 4-5, 8, 12, 2023 at 11:30 a.m., and January 4, 5, 7, 8, 10, 12, 2023, at 5:30 p.m.; - Novolog FlexPen, inject SQ, every night at bedtime per sliding scale: administered January 4, 6-8, 2023, at 10:00 p.m. R3's record lacked signed prescriber orders for the above-listed medications. On February 1, 2023, at 1:00 p.m., interim registered nurse (RN)-A stated it would be expected they have signed orders on admission and with any medication changes for R2 and every other resident. On February 9, 2023 at 11:47 a.m., post survey, RN-A provided a signed order, dated February 1, 2023, for insulin administration for R3. The order noted changes daily insulin orders, blood glucose testing frequency and discontinued previous insulin orders. The licensee's Medication Management Services-AL policy, dated August 7, 2019, indicated, "The [director of health services] DHS will ensure that there is a signed prescription for all medications that we manage for our residents, including over-the-counter medications and supplements." No further information was provided.	01820		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 61 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 monitor the temperature of one of two medication storage refrigerators to ensure required medications were stored according to manufacturer directions for four of five residents (R1, R6, R10, R11). Further the licensee failed to double-lock controlled medications for 2 of 6 residents (R2, R6) reviewed for medication storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: STORAGE OF CONTROLLED MEDICATIONS On January 30, 2023 at 11:01 a.m., during the entrance conference, RN-A stated medications that were administered by staff were stored in a	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 62	01880		

locked box inside each residents apartment. RN-A further stated controlled medications were also kept in the locked box, and were not secured under an additional lock inside the box.

R2
R2's service plan, dated March 29, 2022, indicated R2 received services including assistance with medication management.

R2's medication management plan, dated January 5, 2023, indicated R2's narcotic (controlled substances) medications would be set-up by a nurse like other medications, placed in a single locked box, then placed in the residents room for the unlicensed personnel (ULPs) to assist with administration.

R2's record included a prescriber order, dated December 6, 2022, indicating Adderall (for attention deficit disorder), 30 milligram (mg) tablet, take half a tablet two times per day.

A Medication Incident Report Form, dated January 3, 2023, indicated R2 accessed his medication storage box on January 2, 2023, and self-administered his medications, including "amphet/dextr [amphetamine/dextroamphetamine] tab [tablet] 15 mg," (Adderall).

An Internal Investigation of Incident form, completed January 5, 2023, indicated R2 accessed his medication box on January 2, 2023, and self-administered his own medications.

On January 31, 2023, at 7:19 a.m., R2 stated he broke into his medication box to access his medications on January 2 and 20, 2023. R2 stated the Adderall was not kept behind a second

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 63	01880		

lock, it was "just in the medication box" along with the rest of his medications.

On January 31, 2023, at 8:12 a.m., ULP-J stated R2's medication box contained his Adderall while stored in his room.

On January 31, 2023, at 12:46 p.m., registered nurse (RN)-B stated R2 broke the lock and accessed his medication box twice. RN-B further stated Adderall was stored in the medication box at the time of both incidents.

On February 1, 2023, at 10:26 a.m., regional director of clinical services (RDCS)-D stated she would assume R2's Adderall was kept in his medication box and was not double-locked.

R6
R6's service plan, dated July 26, 2021, indicated R6 received services including assistance with blood glucose management, and medication management.

R6's medication management plan dated August 22, 2022, indicated R6's medications included narcotics/controlled substances.

R6's MAR for January 2023 indicated R6 was administered:
-haloperidol (antipsychotic) 2 mg 1 tablet by mouth at bedtime; and
-pregabalin (for neuropathy (nerve pain)) 100 mg, one capsule three times daily.

On January 31, 2023, at 12:34 p.m., during a medication administration observation, R6's pregabalin was observed not secured under an additional lock inside R6's locked medication box. ULP-H stated controlled medications were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01880	Continued From page 64 double locked, but were kept in the locked medication box with the other medications. ULP-H further stated ULPs initial and count the medications during each administration, and if the count was incorrect, they would contact the nurse. MEDICATION REFRIGERATOR STORAGE On January 30, 2023, at 1:45 p.m., the nursing office medication refrigerator was observed with RN-A. The refrigerator had two thermometers, the first was a traditional thermometer approximately 4 inches (in.) in length and the second a traditional thermometer approximately 6 in. in length. The temperature reading on both thermometers was 41 degrees Fahrenheit (F). A clear sleeve filled with, "Temperature Log for Refrigerator and Freezer," forms was observed taped to the front of the refrigerator. The sleeve included temperature log forms for June through December, 2022, and lacked a log form for January 2023. The most recent recorded temperature was July 5, 2022, indicating 41 degrees F. The middle shelf of the refrigerator had a puddle of standing water in which two plastic bags filled with insulin pens were sitting. The wall in the back of the refrigerator was covered with large drops of condensation, some drops were running down the back wall onto the middle shelf. The medication refrigerator contained the following resident medications: - R1 - Novolog (a fast-acting insulin) Mix 70/30 flexpen 100 units (u), expiration date November 3, 2023, one black and purple flexpen; - R1 - Trulicity (dulaglutide, for diabetes) 1.5 mg/0.5 milliliter (ml) pen injector, expiration date January 24, 2024, box contained four single dose pens; - R6 - Novolog injection flexpen, 100 u/ml, expiration date December 27, 2023, 10 blue and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 65 orange flexpens; - R6 - Lantus (a long-acting insulin) SoloStar injection pen 100 u/ml, expiration date December 5, 2023, five gray and purple pens; - R10 - Lantus SoloStar injection pen 100 u/ml, expiration date December 23, 2023, two gray and purple pens; - R10 - Ozempic (semaglutide, for diabetes) 2 mg/1.5 ml, expiration date November 7, 2023, box contained one pen; and - R11 - Lantus SoloStar injection pen 100 u/ml, expiration date January 23, 2024, three gray and purple pens. On January 30, 2023, at 1:45 p.m., RN-A stated the refrigerator temperature log should be filled out daily. RN-A stated the standing water and condensation could be caused by a fluctuation in temperature of the refrigerator. RN-A further stated she had only been at the facility for a little over a week and was in the process of fixing these types of problems. Manufacturer directions for Trulicity pen injector, revised December 2022, indicated, "Store TRULICITY in the refrigerator at 36°F to 46°F (2°C to 8°C). If needed, each single-dose pen can be kept at room temperature, not to exceed 86°F (30°C) for a total of 14 days. Do not freeze TRULICITY. Do not use TRULICITY if it has been frozen." Manufacturer directions for Novolog flexpen, revised December 2020, indicated unopened pens could be stored refrigerated (36-42 degrees F) until the expiration date, or at room temperature (below 86 degrees F) for 28 days. Manufacturer directions for Lantus SoloStar injection pen, revised December 2020, indicated	01880		

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	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01880	Continued From page 66 unopened pens could be stored refrigerated (36-42 degrees F) until the expiration date, or at room temperature (below 86 degrees F) for 28 days. Manufacturer directions for Ozempic dated October 2022, indicated, "Prior to first use, OZEMPIC® should be stored in a refrigerator between 36ºF to 46ºF (2ºC to 8ºC)." The directions further indicated, "Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze OZEMPIC® and do not use OZEMPIC® if it has been frozen. After first use of the OZEMPIC® pen, the pen can be stored for 56 days at controlled room temperature (59°F to 86°F; 15°C to 30°C) or in a refrigerator (36°F to 46°F; 2°C to 8°C)." The licensee's Medication Storage-AL policy dated December 18, 2019, indicated, "Medications and vaccines requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses ' station or other secured location. Refrigerator temperature should be maintained between 36-46 degrees F. Medications must be stored separately from food and must be labeled accordingly." The licensee's Controlled Substances-AL policy, revised May 18, 2021, indicated, "This agency will take all reasonable precautions to eliminate the theft or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01910	Continued From page 67	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R7). Further, the licensee failed to dispose of expired and unused medication for one of six residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01910	Continued From page 68	01910		

resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R7
R7 was admitted August 31, 2022, and discharged December 19, 2022. R7 received services including assistance with medication administration.

R7's medication administration record (MAR) for December 1-19, 2022, indicated R7 was administered the following scheduled medications:
-Baclofen (for pain) 10 milligrams (mg), twice daily;
-calcium/vitamin D supplement, once daily;
-clopidogrel (anti-platelet) 75 mg, once daily in a.m.;
-Gabapentin (for pain) 300 mg, twice daily;
-Losartan (for high blood pressure) 50 mg, twice daily;
-Metoprolol (for high blood pressure) 100 mg, once daily;
-potassium chloride supplement 10 milliequivalents (meq), once daily;
-senna S (for constipation) 8.6-50 mg, twice daily;
-atorvastatin (for high cholesterol) 40 mg, once daily at bedtime.

The MAR further indicated the following prescribed medications were available to be administered as needed (PRN):
-Acetaminophen 500 mg, two tablets every four hours as needed for pain;
-bacitracin/zinc ointment, apply to affected area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01910	Continued From page 69	01910		

topically once per day as needed;
-flutiocasone (for dry nose) 50 micrograms (mcg) nasal spray, two sprays in each nostril once per day as needed.

R7's record included a discharge summary, dated December 19, 2022, indicating R7 discharged to another assisted living facility. The discharge summary indicated medications were sent with the resident and, "see medication disposition". R7's record lacked a medication disposition form, or other information related to the transfer or disposition of medications to include the quantity of medications and who received the medications upon discharge.

On January 30, 2023, at 4:10 p.m., registered nurse (RN)-A provided the discharge summary, and stated she was not able to locate the medication disposition record. RN-A further stated the disposition documentation was possibly kept elsewhere.

On February 1, 2023, at approximately 9:00 a.m., regional director of clinical services (RDCS)-D stated there was no record of medication disposition upon discharge available for R7.

R3
R3's service plan, dated September 6, 2022, indicated R3 received services including assistance with medication administration.

On January 31, 2023, at 8:46 a.m., during a medication administration observation, R3's medication storage box was observed to contain one novolog (a fast-acting insulin) kwikpen labeled with an opened date of October 14, 2022 (109 days prior).
-ULP-E verified the date observed on the pen and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01910	Continued From page 70 stated R3 was no longer administered the novolog insulin. ULP-E further stated nurses checked the medication boxes weekly and they would be responsible for removing any unused or expired medications. On January 31, 2023, at 9:11 a.m., RN-B stated resident medication boxes are reviewed weekly. RN-B verified the open date on the insulin pen was October 14, 2022. RN-B was not aware when opened insulin pens should be discarded, and stated they would use the pen until it was empty. RN-B further stated the pen should be good until the manufacturer expiration date printed on the pen. Manufacturer recommendations for novolog insulin, updated March 2021, indicated opened pens could be stored at room temperature below 86°F (30°C) for up to 28 days, and, "should be thrown away after 28 days, even if it still has insulin left in it." The licensee's Disposition of Medication-AL policy, undated, indicated for discharged residents, "Staff will document the Disposition of Medications in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining." The policy further indicated, "Discontinued or unused medications should be destroyed within 1 month of discontinuation, expiration of the medication, or the death or discharge of the resident." No further information provided. Time period for correction: Twenty-one (21) days	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01960	Continued From page 71	01960		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for three of six residents (R1, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's service/treatment plan, dated May 18, 2022, indicated R1 received assistance with blood glucose monitoring two times daily. R1's record included prescriber orders signed November 30, 2022, indicating blood glucose	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01960	Continued From page 72 levels to be tested two times daily starting November 30, 2022. R1's service check list (which was also used for treatment documentation) for January 2023, lacked documentation of blood glucose checks for the following dates and times: - January 11-20, 2023, for the 8:30 a.m. daily check; and - January 10-20, 2023, for the 4:30 p.m. daily check. R3's service/treatment plan signed September 6, 2022, indicated R3 received assistance with blood glucose monitoring 1-2 times daily. R3's service check list (which was also used for treatment documentation) for January 2023, lacked documentation of blood glucose checks for the following dates and times: - January 24, 2023, for the 8:30 a.m. daily check; - January 24, 2023, for the 10:45 a.m. daily check; and - January 2, 3, and 6, for the 5:30 p.m. daily check. R6's service/treatment plan signed July 26, 2021, indicated R6 received assistance with blood glucose monitoring 3-4 times daily. R6's record included prescriber orders signed January 26, 2023, indicating blood glucose levels to be tested three times daily starting July 9, 2019. R6's service check list (which was also used for treatment documentation) for January 2023, lacked documentation of blood glucose checks for the following dates and times: - January 2, 18, and 20, 2023, 9:30 a.m. daily	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01960	Continued From page 73 check; - January 2, 10, 18, and 20, 2023, 12:00 p.m. daily check; and - January 26, 2023, 5:00 p.m. daily check. On February 1, 2023, at 12:52 p.m., regional director of clinical services (RDCS)-D stated they were aware of the documentation issues. RDCS-D stated their software sends a message/alert banner to nursing when documentation is missed. RDCS-D stated she recently discussed with the interim registered nurse (RN)-A and they found nurses were not following up with the alert banners and were in the process of addressing the problem. The licensee's Treatment or Therapy Services-AL policy, dated August 7, 2019, indicated: "9. All therapy or treatment ordered will be provided according to the Treatment/Therapy Plan. If the therapy or treatment is not given as ordered documentation will be made to indicate the reason for the exception. 10. All therapy provided will be documented on the MAR. 11. The nurse will monitor documentation monthly and review all therapy and treatments ordered for the resident at least every 90 days." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
02310 SS=D	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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 74 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping for 2 of 2 residents reviewed for O2 storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R8 R8's service plan, dated June 26, 2020, indicated R8 received services including assistance with bathing, housekeeping, and laundry. R8's plan of care, printed February 3, 2023, indicated R8 received assistance with O2, including "ensure resident is wearing O2" and "use portable tank when leaving apartment". On January 31, 2023, at 10:50 a.m., R8's room was observed to have 11 small canister-style, 170 milliliter (ml) O2 tanks on the floor, positioned approximately 6 inches away from a baseboard heat source, and not secured to prevent tipping. Six tanks were identified as unopened (with a seal present and intact) and five appeared used,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 75 lacking the seal. One additional, larger tank was observed to be secured upright in a wheeled cart. On January 31, 2023, at 10:53 a.m., unlicensed personnel (ULP)-E indicated ULPs assisted R8 by switching R8's tubing to the portable tanks when she went out to appointments. ULP-E stated she did not know about O2 canister storage safety. R9 R9's service plan, dated July 1, 2022, indicated R9 received services including assistance with bathing, transfers, compression stockings, housekeeping, and laundry. R9's plan of care, printed February 3, 2023, indicated R9 received assistance with O2, including, "Ensure resident has sufficient oxygen and supplies," and "Change tubing as needed". On January 31, 2023, at 8:53 a.m., R9's room was observed to have two canister-style O2 tanks sitting upright on the floor, and not secured to prevent tipping. One additional tank was present, laying horizontally in a carrying bag, in the basket of R9's walker. R9 stated the tanks were 3 liter (L) tanks and were delivered by an oxygen supply company. On January 31, 2023, at 10:56 a.m., registered nurse (RN)-B stated O2 tanks should be stored "away from other objects," and secured to prevent tipping. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 76 of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". R8's O2 supply company storage guidelines document, "Breathe Easy Stay Safe When Using Oxygen," undated, indicated ". "Always keep tanks secured so they cannot fall over or roll." The guidance further indicated, "Oxygen contents are under high pressure and should a tank fall over or become damaged, the valve could open suddenly or even break free. A sudden pressure release could propel the tank injuring someone." R9's O2 supply company storage guidelines document, "Safe Oxygen Cylinder Storage," undated, indicated O2 cylinders should be stored in a company provided metal rack, customer made wood box or wood rack, or chained upright to the wall, with the chains secured into the wall with bolts. The guidance further indicated, "Tanks should be stored at least 10 feet from any heat source and out of direct sunlight." The licensee's Oxygen Usage (AL) policy , reviewed August 1, 2021, indicated, "The [assisted living (AL)] does not have an oxygen storage room, nor does the AL store oxygen for residents. Oxygen company needs to provide storage: green cylinder tanks need to be stored in metal racks only.." The policy further indicated, "Staff are trained on Oxygen Safety/Medical Gases."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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02310	Continued From page 77 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility, including statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 January 30, 2023, at 11:44 a.m., during a tour of the facility, an electronic monitoring notice to	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
03090	Continued From page 78 visitors was observed to be posted at one entrance to the facility identified as the 1510 building. The other entrances to the facility observed, including the 1020, 1509, and 1425 building entrances lacked the electronic monitoring notice to visitors. During the observation, licensed assisted living director (LALD)-C stated she was not sure if the notice was posted at entrances other than the 1510 building entrance. On February 3, 2023, at 2:09 p.m., during the exit conference, Regional Director of Operations (RDO)-F indicated each building entrance was accessible to visitors, and the notices would be added. The licensee's Electronic Monitoring (MN) policy, last reviewed May 26, 2022, indicated the licensee, "shall post a sign at each facility entrance accessible to visitors that states, 'Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities'." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/30/23*
Time: 13:00:00
Report: 1025231024

Food and Beverage Establishment Inspection Report

Location:
Augustana Apartments Of Mpls
1509 10th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0037530
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122385555
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Cold TCS foods in prep cooler held at or above 41 deg F (temperature taken at start, end of inspection). Maintain cold TCS foods at or below 41 deg F. Discard TCS foods end of dinner service; do not store TCS foods overnight in cooler.

Comply By: 01/30/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

Service the prep cooler such cold TCS foods can be maintained at or below 41 deg F on the rail. Clean dust from the condenser.

Comply By: 01/30/23

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at 122 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 150 PPM at Degrees Fahrenheit
Location: Sanitary bucket, from prior service
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Potato salad
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Dressing
Temperature: 41 Degrees Fahrenheit - Location: Dressing upright cooler
Violation Issued: No

Process/Item: Rice
Temperature: 140 Degrees Fahrenheit - Location: Hot holding, upright cabniet
Violation Issued: No

Process/Item: Turkey, deli
Temperature: 43 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: Yes

Process/Item: Roast beef
Temperature: 43 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: Yes

Process/Item: Ham
Temperature: 45 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: Yes

Process/Item: Ambient
Temperature: 30 Degrees Fahrenheit - Location: Undercounter prep cooler
Violation Issued: No

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

Discussed employee health and hygiene, employee illness reporting and exclusion, suppliers, menu. Reported raw shell eggs used for baking only, pasteurized eggs or egg product used otherwise, no service of raw or undercooked animal food. Minimal cooling reported, discussed methods; establishment does not have a 3 compartment sink, has a spray basin and a low temperature dish machine, discussed contingencies for emergencies, power outages, service interruptions, etc. Service for quarantine rooms reported to be delivery of items, use of single use items, reported no additional fee for service. Discussed routine cleaning of in-place equipment (drink dispensers, smoothie/shake machine), replacement of point-of-use filters for equipment. Buffet reported not in use since COVID-19. Quaternary ammonia used (dispenser at utility sink) for food-contact surfaces in kitchen and dining area, discussed sanitizing surfaces after a soap and water wash. Discussed pest control, handwashing, cooking and hot holding, catering and events (have handwashing available for service). Kitchen not in use during inspection. No food preparation observed during inspection. Reported no other food service facilities in the complex for inspection.

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 1025231024 of 01/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231024

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date 01/30/23
No. of Repeat RF/PHI Categories Out	0	Time In 13:00:00
Legal Authority MN Rules Chapter 4626		Time Out

Augustana Apartments Of Mpls	Address: 1509 10th Avenue South	City/State: Minneapolis, MN	Zip Code: 55404	Telephone: 6122385555
License/Permit #: 0037530	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/30/23

Inspector (Signature) Cory Kline