Electronically delivered

June 7, 2022

Administrator
Lakeview Assisted Living
941 10th Street
Heron Lake, MN 56137

RE: Project Number(s) SL30568015

Dear Administrator:

On May 24, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 25, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 25, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 25, 2022, found not corrected at the time of the May 24, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0115-Licensure Categories-144g.10 Subd. 2 = $500.00
0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on May 24, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on May 24, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 = $500.00

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

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

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30568015-1 On May 24, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 25, 2022. At the time of the survey, there were 24 residents, all of whom were receiving services. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	{0 115}		

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{0 115}	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with having a secured unit. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility. During the course of the revisit, the surveyor observed white bars on the sides of the two main doors, which sounded and alerted the resident and staff if the resident was close to the exit.	{0 115}		

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{0 115}	Continued From page 2 R5 R5's diagnoses included Alzheimer's disease and atherosclerosis. R5's Service Plan dated October 13, 2021, indicated the staff were to check R5's wander guard placement two times per day. R5's Assessment As Of Date, dated April 7, 2022, noted R5 was independent with walking and used a walker, would not be able to evacuate without help, no previous attempts to leave the facility alone were noted and was not considered at risk for elopement. In addition, the assessment noted R5 had intermittent confusion. R6 R6's diagnoses included dementia and pancreatitis. R6's Service Plan dated January 19, 2022, indicated the staff were to check R6's wander guard placement once per day. R6's Assessment As Of Date, dated March 13, 2022, noted R6 utilized a manual wheelchair and required assistance to get to specific destinations. In addition, the assessment noted R6 to be at risk for elopement due to confusion, a wander guard was in place, and R6 had not left the building but wandered inside the building. On May 24, 2022, at approximately 3:00 p.m., registered nurse (RN)-A stated the licensee had not applied for an assisted living with dementia care license as they had submitted a request for reconsideration on this citation. No further information was provided.	{0 115}		

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0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on May 24, 2022, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	0 340		

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0 340	Continued From page 4 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the revisit survey on May 24, 2022, the surveyor reviewed the licensee's policies and procedures, resident records, employee records and conducted interviews with registered (RN)-B and RN director (RND)-K. The licensee lacked evidence to indicate the orders issued on March 25, 2022, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 5 This MN Requirement is not met as evidenced by: No further information required.	{0 480}		
{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 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: No further information required.	{0 780}		

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{0 790}	Continued From page 6	{0 790}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further information required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further information required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	{0 810}		

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{0 810}	Continued From page 7 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further information required.	{0 810}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	{0 970}		

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{0 970}	Continued From page 8	{0 970}		

liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety or personal property of a resident. This had the potential to affect all residents.

This practice resulted in a level 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:

The licensee's assisted living contract included:
- Page 7, section 17. Possession of and Damage to the Apartment. "In the event Provider cannot provide Resident with possession of the Apartment upon the effective date of this Agreement, Resident will not be responsible for the payment of any Monthly Fees until such time as Provider makes the Apartment available to Resident for occupancy. Resident agrees not to hold Provider liable for any damages incurred by Resident as a result of the unavailability of the

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{0 970}	Continued From page 9	{0 970}		

Apartment. In the event Resident is unable to take possession of the Apartment for any reason other than the unavailability of the same, Resident agrees that Provider is not liable for damages or monetary loss incurred by Resident as a result of Resident's inability to occupy the Apartment on the date anticipated in this Agreement."
- Page 7, section 18. Personal Property. "Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Provider's control. Resident is strongly encouraged to obtain renter's insurance."
- Page 7, section 19. Guests. "Resident is responsible for the conduct of Resident's guests and is responsible for any damage they may cause to the Apartment or to the premises of Provider."
- Page 9, section 23. 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 or in part by, an act or omission of Resident or Resident's guests or agents."
- Page 10, section 24. Insurance. "Provider will maintain appropriate levels and types of insurance covering the building and its contents. Because Provider does not maintain insurance

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{0 970}	Continued From page 10	{0 970}		

covering the contents of residents' apartments, or garages, if applicable, Resident is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Apartment, as well as any injury to Resident or Resident's guests occurring within the Apartment ("renter's insurance"). Resident acknowledges and understands that the lack of such insurance coverage may result in personal loss to and/or liability to Resident."
- Page 10, section 25. 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, manager, 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 May 24, 2022, at approximately 3:00 p.m., registered nurse (RN)-A stated the contracts had not been changed to remove the above waiver language, as a request for reconsideration had been submitted.

No further information was provided.

{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}		

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{01650}	Continued From page 11 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{01650}		

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	30568	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

(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
{01650}	Continued From page 12	{01650}		

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

The findings include:

R5's diagnoses included Alzheimer's disease and atherosclerosis.

R5's Service Plan dated October 13, 2021, noted services including assistance with bathing and medication management. In addition, the service plan noted "If services to be provided are home care services, an individualized initial assessment will be conducted in person by a registered nurse. This initial assessment will be completed within five days after initiation of home care services." The service plan lacked the schedule of monitoring assessments of the resident to include:
- the facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident 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.

On May 24, 2022, at approximately 1:25 p.m., registered nurse (RN)-A confirmed R5 did not have a revised service plan with the correct information regarding the assessment frequency.

The licensee's Service Plan policy dated August 1, 2022, noted the service plan must include the schedule and method for the next planned assessment or monitoring.

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{01650}	Continued From page 13 No further information was provided.	{01650}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	{01700}		

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{01700}	Continued From page 14	{01700}		

(RN) conducted an individualized assessment with the required content for four of four residents (R1, R2, R3 and R9) with records reviewed.

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

The findings include:

During the revisit entrance conference on May 24, 2022, at approximately 9:45 a.m., registered nurse (RN)-A stated the licensee provided medication management services to the licensee's residents.

R1, R2, R3 and R9's records lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all mediations the resident was known to be taking;
- indications for medications;
- side effects;
- contraindications; and
- allergic or adverse reactions and actions to address those issues.

R1
R1's Service Plan dated August 1, 2021, indicated R1 received services including assistance with medication administration and catheter cares.

R1's prescriber orders dated March 29, 2022,

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{01700}	Continued From page 15 included one pain medication and one medication for depression. R1's medication assessment dated April 23, 2022, noted "Face-to-face assessment/review of medication management services was completed by the RN, including review of services and medications (prescription, over-the-counter, and supplements), side effects, contraindications, allergic or adverse reactions, and actions to address these issues". It also noted "Edit note" dated May 24, 2022, by RN-A. R1's May 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R2 R2's Service Plan dated April 28, 2022, indicated R2 received services including assistance with medication administration, blood glucose and catheter cares. R2's prescriber orders dated March 4, 2022, included, but were not limited to, three medications to lower blood glucose levels and two medications to lower blood pressure. R2's medication assessment dated April 23, 2022, noted "Face-to-face assessment/review of medication management services was completed by the RN, including review of services and medications (prescription, over-the-counter, and supplements) side effects, contraindications, allergic or adverse reactions, and actions to address these issues". It also noted "Edit note" dated May 24, 2022, by RN-A. R2's May 2022 Med (Medication) Admin	{01700}		

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{01700}	Continued From page 16 (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R3 R3's Service Plan dated March 22, 2022, indicated R3 received services including assistance with medication administration and activities of daily living. R3's medication assessment dated April 23, 2022, noted "Face-to-face assessment/review of medication management services was completed by the RN, including review of services and medications (prescription, over-the-counter, and supplements) side effects, contraindications, allergic or adverse reactions, and actions to address these issues". It also noted "Edit note" dated May 24, 2022, by RN-A. R3's prescriber orders dated March 4, 2022, included one medication to increase thyroid levels and one pain medication. R3's May 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R9 R9's Service Plan dated June 1, 2021, noted services including assistance with medication management and blood glucose. R9's prescriber orders dated June 1, 2021, included one statin and one blood pressure reducing medication. R9's Assessment As Of Date dated March 13, 2022, noted "Nurse reviews all medications. Staff	{01700}		

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{01700}	Continued From page 17 monitors for medication side effects and any safety concerns, which are reported immediately to licensed staff." However, the assessment lacked the above required content. R9's May 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On May 24, 2022, at approximately 2:55 p.m., RN-A stated she had made the edits to the assessments, which included the date of May 24, 2022, prior to providing the requested copies to the surveyor. In addition, RN-A stated prior to this, no resident assessments included the above required content. The licensee's Medication Management: Assessment, Monitoring & Reassessment policy dated August 1, 2021, noted the assessment must include an identification and review of all medications the resident is known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address those issues. No further information was provided.	{01700}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	{01940}		

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{01940}	Continued From page 18 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R9) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	{01940}		

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{01940}	Continued From page 19 situation has occurred only occasionally). The findings include: During the revisit entrance conference on May 24, 2022, at approximately 9:45 a.m., registered nurse (RN)-A stated the licensee provided medication management services to the licensee's residents. R9's record lacked a treatment management plan to include: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a RN when a problem arose with treatment or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complication s or adverse reactions. R9's Service Plan dated June 1, 2021, noted services including assistance with medication management and record blood glucose three days a week. R9's prescriber orders dated June 1, 2021, included an order to record blood glucose three days a week. On May 24, 2022, at approximately 12:25 p.m., RN-A confirmed R9 lacked a treatment management plan with the required content prior	{01940}		

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{01940}	Continued From page 20 to the surveyor entering today. The licensee's Treatment & Therapy: Management Plan policy dated August 1, 2021, noted the treatment and therapy management record must include a statement of the type of services that would be provided, documentation of specific resident instructions relating to the treatments or therapy administered, identification of treatment or therapy tasks that would be delegated to unlicensed personnel, procedures for notifying an RN when a problem arose with treatments or therapy services, any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.. No further information was provided.	{01940}		
{02290} SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of two of two residents (R3 and R9) reviewed when the licensee required the resident or their representative to sign a risk agreement waiving the licensee's liability regarding the use of bedrails.	{02290}		

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{02290}	Continued From page 21 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's diagnoses included cognitive impairment. R3's Negotiated/Shared Risk Agreement - Bed Rail form dated July 26, 2021, included an assessment of the zones of entrapment, identified the use of the bedrails to be for turning and repositioning and included a risk and benefit statement that noted Bedrails pose a risk of injury including sprains, strains and fractures. Bed rails pose a risk of entrapment which can lead to suffocation and death." In addition, the agreement noted by signing the form, the resident had agreed to bear the risk, whether of personal injury, property damage or loss, or any other consequences which can result by violation of the agreement and/or the resident's behaviors or activities as outlined in the agreement. R9 R9's diagnoses included ischemic stroke. R9's Negotiated/Shared Risk Agreement - Bed Rail form dated July 21, 2021, included an assessment of the zones of entrapment, identified the use of the bedrails to be for turning and repositioning and included a risk and benefit	{02290}		

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{02290}	Continued From page 22 statement that noted Bedrails pose a risk of injury including sprains, strains and fractures. Bed rails pose a risk of entrapment which can lead to suffocation and death." In addition, the agreement noted by signing the form, the resident had agreed to bear the risk, whether of personal injury, property damage or loss, or any other consequences which can result by violation of the agreement and/or the resident's behaviors or activities as outlined in the agreement. On May 24, 2022, at approximately 3:00 p.m., registered nurse (RN)-A stated the licensee had not made any changes as they had submitted a request for reconsideration on this citation. No further information was provided.	{02290}		

Electronically Delivered

April 11, 2022

Administrator
Lakeview Assisted Living
941 County Road 9
Heron Lake, MN 56137

RE: Project Number(s) SL30568015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 25, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $^,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed 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. 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30568015 On March 22, 2022, through March 25, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on March 23, 2022, issued for SL30568015, tag identification 2310. On March 24, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G. An immediate correction order was identified on	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 000	Continued From page 1 March 24, 2022, issued for SL30568015, tag identification 0510. On March 25, 2022, the immediacy of correction order 0510 was removed, however non-compliance remained at a scope and level of I.	0 000		
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with having a secured unit. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 115		

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0 115	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility. During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the facility did not have a secure dementia unit, but they did have residents with a diagnosis of dementia or Alzheimer's disease. R5 R5's diagnoses included Alzheimer's disease and atherosclerosis. R5's Service Plan dated October 13, 2021, indicated the staff were to check R5's wander guard placement two times per day. R5's Assessment As Of Date, dated January 9, 2022, noted R5 was independent with walking and used a walker, would not be able to evacuate without help, and no previous attempts to leave the facility alone were noted, and was not considered at risk for elopement. In addition, the assessment noted R5 had intermittent confusion. R6 R6's diagnoses included dementia and pancreatitis. R6's Service Plan dated January 19, 2022, indicated the staff were to check R6's wander guard placement once per day.	0 115		

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0 115	Continued From page 3 R6's Assessment As Of Date, dated March 13, 2022, noted R6 utilized a manual wheelchair, and required assistance to get to specific destinations. In addition, the assessment noted R6 to be at risk for elopement due to confusion, a wander guard was in place, and R6 had not left the building but wandered inside the building. On March 22, 2022, at approximately 2:40 p.m., RM-B confirmed the licensee utilized a wander guard system. The surveyor along with RM-B observed white bars on the sides of the main door, which sounded and alerted the resident and staff if the resident was close to the exit. RM-B stated according to the emergency exit map, there was a total of seven exits to the outside of the facility, all of which had the white bars. On March 22, 2022, at approximately 3:26 p.m., RM-B stated the intent of the wander guard was to alert staff when a resident was attempting to exit the building, and to limit, not prevent the resident from exiting. RM-B stated the staff would be able to go outside with the resident, to be with them. In addition, RM-B stated there were two residents with the wander guard in place, R5 and R6. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 115		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose	0 250		

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0 250	Continued From page 4 a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services;	0 250		

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0 250	Continued From page 5 (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided its residents with medication and treatment management services.	0 250		

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0 250	Continued From page 6 The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing	0 250		

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0 250	Continued From page 7 of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as	0 250		

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0 250	Continued From page 8 required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-J on May 10, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued [0115, 0470, 0480, 0510, 0550, 0620, 0640, 0660, 0680, 0780, 0790, 0800, 0810, 0900, 0910, 0970, 1420, 1440, 1470, 1530, 1620, 1640, 1650, 1700, 1730, 1790, 1890, 1910, 1940, 2290, 2310, 3000, and 3030], indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for	0 250		

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0 250	Continued From page 9 compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the 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;	0 470		

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0 470	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license, was licensed for a bed capacity of 27 residents and at the time of the survey had a census of 21 residents. The licensee failed to post a current staffing schedule. During the entrance conference on March 22, 2022, at approximately 11:30 a.m., registered nurse (RN)-A and regional manager (RM)-B stated the licensee had no staffing schedule posted. In addition, they noted there were two shifts, from 6:00 a.m. to 6:00 p.m., and 6:00 p.m. to 6:00 a.m., with two unlicensed personnel (ULP) scheduled on each shift. During the initial facility tour on March 22, 2022, at approximately 12:00 p.m., with RN-A, the surveyor observed an Assisted Living Staffing	0 470		

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0 470	Continued From page 11 sheet posted outside the nurse's office, dated "8/9/21 - change of res. [resident]". The posting indicated two staff from 6:00 a.m. to 6:00 p.m., one staff from 6:00 a.m. to 2:00 p.m., and two staff from 6:00 p.m. to 6:00 a.m. In addition, an RN was available on call. RN-A stated she was not aware the schedule was there and verified it was not accurate. The licensee's Staffing & Scheduling policy dated August 1, 2021, noted the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility, accessible to staff, residents, volunteers and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 12 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 of the licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report dated March 24, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 13 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control, for two of two residents (R1 and R8) who utilized a Hoyer lift. This had to potential to affect all residents of the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents.) This practice resulted in an immediate correction order on March 24, 2022, related to residents identified as R1 and R8. The findings include: R1's prescriber order dated March 15, 2022, indicated a C-difficile (c.diff) stool test for diarrhea. R1's Resident notes dated March 16, 2022, noted	0 510	On March 25, 2022, the immediacy of correction order 0510 was removed, however non-compliance remained at a scope and level of I.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 14 R1 was seen by her provider, and the licensee received an order for a c.diff stool test (a bacteria that causes diarrhea). On March 23, 2022, at approximately 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-D transfer R1 from her bed to her wheelchair. Before entering R1's room, the surveyor observed no signage near R1's door to indicate she was on contact precautions or isolation precautions. Prior to entering, staff donned disposable gowns and gloves from a plastic drawer compartment located in the hall across from R1's room and stated it was because R1 was being tested for c.diff. The staff brought a Hoyer lift (a mechanical lift utilized to transfer a person) into the room with them to facilitate the transfer. After exiting R1's room, the staff doffed the gowns and gloves and disposed of them in a round covered receptacle across the hall from R1's room and performed hand hygiene with hand sanitizer. Staff removed Lysol disinfecting wipes from one of the plastic drawers to cleanse the Hoyer lift. The surveyor inquired if the Lysol disinfecting wipes were effective against c.diff, they stated they were unsure. On March 23, 2022, at approximately 11:35 a.m., registered nurse (RN)-A stated she was unsure what was recommended to clean the lift that would be effective on c.diff. The surveyor asked RN-A to look at manufacturer recommendations for what would be effective including the required amount of contact time and to implement immediately. On March 24, 2022, at approximately 3:15 p.m., the surveyor observed the Lysol disinfecting wipes utilized by staff and verified the product was not on the Environmental Protection Agency	0 510		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 510	Continued From page 15 (EPA) list as effective against c.diff. On March 24, 2022, at approximately 3:28 p.m., licensed assisted living director (LALD)-E stated one other resident (R8) also utilized the same Hoyer lift. On March 24, 2022, at approximately 3:35 p.m., RN-A stated R1 was on contact precautions. On March 24, 2022, at approximately 3:58 p.m., LALD-E stated the contact precautions started on March 15, 2022. On March 24, 2022, at approximately 4:20 p.m., LALD-E stated a daily room cleaning was not being done for R1. On March 24, 2022, at approximately 5:00 p.m., ULP-H stated she had been instructed that R1 was on precautions and could not come out of her room. ULP-H stated the information was passed on from staff to staff between shifts, although ULP-H stated R1 left her room for an appointment today. On March 24, 2022, at approximately 5:10 p.m., office assistant (OA)-I stated the R1 utilized a transportation company to go to her appointment today, and the licensee did not inform the transportation company the resident was on precautions. Also at this time, LALD-E stated the transport company should have been notified and instructed OA-I to call the company to let them know. A policy related to c.diff was requested but not available. The licensee's Standard Precautions policy dated	0 510		

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0 510	Continued From page 16 September 20, 2021, lacked instruction on the use of or cleaning of shared medical equipment. The licensee's Cleaning of Shared Medical Equipment dated September 20, 2021, noted all equipment must be cleaned immediately if visibly soiled, and immediately after use for residents with contact precautions, including c.diff. Minnesota Department of Health's Clostridiodes (Clostridium) difficile Infection Prevention updated January 31, 2022, included a link to a list of EPA registered products effective against Clostridiodes (Clostridium) difficile spores. It also noted to implement daily room cleaning using EPA approved cleaners, consider pre-emptively placing CDI (Clostridium difficile Infection) symptomatic patients on contact precautions until laboratory results are available and to implement isolation precautions indicating that patients should not leave their room unless medically necessary and that any other receiving providers or key staff such as environmental services, dietary, PT/OT, etc., should be notified of the precautions. TIME PERIOD FOR CORRECTION: Immediate *UPDATE* On March 25, 2022, the immediacy of correction order 0510 was removed, however non-compliance remained at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 17 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 18 During the initial tour on March 22, 2022, at approximately 12:00 p.m., with registered nurse (RN)-A, the surveyor observed a grievance form outside the nurse's office, but no grievance procedure. On March 22, 2022, at approximately 12:25 p.m., regional manager (RM)-B verified the grievance procedure was not posted as required. The licensee's Complaint - Grievance Posting policy dated August 1, 2021, noted the licensee would post, in a conspicuous place, information about the complaint and grievance procedure including the name, telephone number, and email contact information for the person responsible for handling resident complaints and grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 620 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 620		

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0 620	Continued From page 19	0 620		

review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for three of three residents (R3, R7 and R8) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on March 22, 2022, at approximately 11:30 a.m., a request was made to regional manager (RM)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2022.

On March 23, 2022, the surveyor received an anonymous complaint of the following:
- R3 reported staff had "flicked" her nose with their fingers over the weekend;
- R7 reported staff on the night shift pulled the walker away from him, putting it too far in front of him when he is trying to walk; and
- R8 was found on the floor when the day staff went in to provide medication administration.

R3
R3 admitted to the facility on July 20, 2021, with diagnoses including cognitive impairment.

R3's Service Plan dated July 20, 2021, indicated

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0 620	Continued From page 20 R3 received services including assistance with medication administration and activities of daily living. R3's Assessment As Of Date, dated February 15, 2022, noted R3 was at risk to be abused. R3's Resident Notes from January 22, 2022, through March 22, 2022, lacked information on the incident. R7 R7 admitted to the facility on August 9, 2021, with diagnoses including cerebral infarction, difficulty walking and muscle weakness. R7's Service Plan dated December 17, 2021, indicated R7 received services including assistance with medication administration and activities of daily living. R7's Assessment As Of Date dated February 15, 2022, noted R7 was at risk to be abused, and staff were to perform nightly safety checks, encourage to perform activities of daily living, and provide time to express himself. R7's Resident Notes from February 1, 2022, through March 24, 2022, lacked information on the incident. R8 R8 admitted to the facility on August 19, 2020, with diagnoses including chronic pain and mild dementia. R8's Service Plan dated August 1, 2021, indicated R8 received services including assistance with medication administration, positioning and transfers.	0 620		

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0 620	Continued From page 21 R8's Assessment As Of Date dated February 14, 2022, noted R8 was at risk to be abused, and indicated R8 required assistance to be turned and repositioned. R8's Resident Notes dated March 12, 2022, included a note authored by registered nurse (RN)-A that noted "Staff called this writer and stated that pt. [patient] was found on bedside matt [sic] on floor next to pt's bed. Pt. was c/o [complaining of] pain in various areas. Directed staff to call pt's daughter and send pt. to ER [emergency room] to be checked out. Ambulance was called and pt. was sent to the ER. Pt. later returned with findings of UTI [urinary tract infection], and instructions to ice swollen/painful areas on and off over next days. Pt. was also started on Cipro 250mg [250 milligrams] by mouth two times per day for UTI." The Continued Investigation typed document, unsigned, and dated March 16, 2022, noted the following: - Asked staff to show how R8's bed pressure alarm worked. All attempts to get the alarm to work failed, even though it had been reported to be working earlier in that day. - Visited R3 asking if there was trouble over the weekend. Resident reported she missed her loved ones and became teary eyed. R3 also stated staff wanted her to go to bed at 7:30 p.m., but she wanted to go to bed at 9:30 p.m. When asked if staff had flicked or poked at her nose, R3 denied, but stated they had tapped her nose while stating "listen to us; we know what we are doing." R3 added staff stated this when they were telling her it was time to go to bed at 7:30 p.m. - Visited R7 to ask if there was any trouble with staff over the weekend. R7 stated yes, he had	0 620		

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0 620	Continued From page 22 been looking for staff to help him to the bathroom, but didn't see anyone around, so he wheeled his wheelchair in front of the bathroom door, and self-transferred to the toilet. Staff then barged into his room and began hollering at him "you can't do this by yourself!" and attempted to pull the wheelchair away, but R7 grabbed it and said he was stronger than the staff, who let the chair go. He was then assisted to the recliner or bed and noticed his footrests were missing from his wheelchair. R7 stated "that night crew, they are directly to the point and mean." On March 24, 2022, at approximately 10:32 a.m., regional manager (RM)-B stated she received a text while on vacation of the concerns from March 12, 2022, and asked staff to reach out to the nurse on call, registered nurse (RN)-A. Also at approximately 10:32 a.m., RN-A stated she was contacted by staff on March 12, 2022, and RN-A stated she emailed the corporate RN, licensed assisted living director (LALD)-E and RM-B with concerns immediately, and the corporate RN informed her an investigation would need to be completed. In addition, RN-A confirmed she did not complete the investigation with any of the three residents until March 16, 2022, four days later. RM-B stated the concerns should have been reported to MAARC if deemed suspicious and confirmed the three reports were suspicious. However, the licensee made no reports to MAARC. The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, noted team members who suspect maltreatment of a resident would contact the assisted living director, and if they confirmed the suspicion of maltreatment would contact MAARC no more than 24 hours after the maltreatment was first	0 620		

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0 620	Continued From page 23 suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required by posting the 911 emergency number. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 640		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 640	Continued From page 24 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the initial tour on March 22, 2022, at approximately 12:00 p.m. with registered nurse (RN)-A, the surveyor observed the entrance and common areas and noted there was no posting of the 911 emergency number, as required. On March 22, 2022, at approximately 12:25 p.m., regional manager (RM)-B verified the licensee lacked a posting of the 911 emergency number. The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, noted the facility would post the 911 emergency number in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 660	Continued From page 25 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 660	Continued From page 26 The licensee's Facility Tuberculosis (TB) Risk Assessment dated August 9, 2021, indicated a low risk level. RN-A RN-A was hired under the comprehensive home care license on June 14, 2022, and began providing assisted living services on August 1, 2021. RN-A's employee record contained a TST administered on July 16, 2021, read on July 19, 2022, (33 days after hire date). ULP-D ULP-D started employment and began providing assisted living services on August 4, 2021. ULP-D's employee record contained a TST administered on September 21, 2021, (48 days after hire date). On March 24, 2022, at approximately 2:55 p.m., regional manager (RM)-B confirmed RN-A was in contact with residents July 12, 2021, two days before the first TST was administered. In addition, RM-B verified ULP-D was in contact with residents August 17, 2021, and confirmed both employees' first TST were administered late. The licensee's Tuberculin Skin Testing (TST) Protocol for Screening Health Care Workers dated October 4, 2021, noted pre-employment screening for healthcare workers included administration of a two-step TST. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July	0 660		

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 660	Continued From page 27 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 680	Continued From page 28 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 24, 2022, at approximately 1:00 p.m., the surveyor reviewed the emergency preparedness plan and Appendix Z with licensed assisted living director (LALD)-E. LALD-E confirmed the licensee lacked a plan to include the following required content: - identification of at-risk population needs like maintaining independence, communication, transportation, supervision and medical care; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 29 maintain integrated response; - a policy and procedure to address safe evacuation from the facility, including consideration of care and treatment needs of evacuees and staff responsibilities; and - a communication plan including residents' physicians, other facilities, and volunteers. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2022, noted the emergency preparedness plan would include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 sleeping unit, interconnect all smoke alarms so	0 780		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 780	Continued From page 30 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that 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 a facility tour on March 24, 2022, at approximately 10:30 a.m. with Director of Environmental Services (DES)-F and Maintenance (M)-G, it was observed that the double sized sleeping room in the northwest wing was equipped with smoke alarms that were not interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by DES-F and M-G accompanying on the tour.	0 780		

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0 780	Continued From page 31 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide fire extinguishers with no more than 75 feet travel distance in the facility. 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:	0 790		

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0 790	Continued From page 32 On a facility tour on March 24, 2022, at approximately 10:30 a.m. with Director of Environmental Services (DES)-F and Maintenance (M)-G, it was observed that there was not any fire extinguisher along the main corridor from the main entrance to fire extinguisher located within the dining room which exceeded the travel distance requirements for an R-3 facility. This deficient condition was visually verified by DES-F and M-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a	0 800		

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 800	Continued From page 33 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 a facility tour on March 24, 2022, at approximately 10:30 a.m. with Director of Environmental Services (DES)-F and Maintenance (M)-G, it was observed that there was water damage to large number of ceiling tiles in the salon. During interview, DES-F stated that there were issues with water pipes above the ceiling and condensation coming from these pipes and that the issue had been addressed, but the tiles had not been replaced yet. On the same tour, it was also observed that the cover was missing from an electrical junction box in the ceiling of the utility room in the northwest wing. On the same tour, it was also observed that there was mold on the ceiling of the utility room of the southwest wing. On the same tour, it was also observed that the fire sprinkler system had not had an annual maintenance inspection conducted since September of 2020. An annual maintenance inspection of fire sprinkler system is required. These deficient conditions were visually verified by DES-F and M-G accompanying on the tour.	0 800		

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0 800	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The 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.	0 810		

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0 810	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to conduct required evacuation drills. 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 a large portion or all of the residents). Findings include: A record review and interview were conducted on March 24, 2022, at approximately 9:45 a.m. with Licensed Assisted Living Director (LALD)-E and Regional Manager (RM)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, LALD-E stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that that the licensee did not have documentation indicating that	0 810		

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 810	Continued From page 36 evacuation drills had been conducted every other month as required. During interview, LALD-E stated that the licensee had not conducted any evacuation drills for the facility since the new law went into effect on August 1, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the	0 900		

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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0 900	Continued From page 37 opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a complete unsigned copy of the contract to the Office of Ombudsman for Long-Term Care. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of the contract as required. On March 24, 2022, at approximately 12:25 p.m., licensed assisted living director (LALD)-E confirmed an unsigned copy of the contract had not been provided to the Office of Ombudsman for Long-Term Care. A policy related to the content of the contract was	0 900		

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0 900	Continued From page 38 requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=D	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a contract with the required content for one of three residents (R3) with records reviewed. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	0 910		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 910	Continued From page 39 situation has occurred only occasionally). The findings include: R3's Assisted Living Contract: Summary & Contact Information dated August 1, 2021, signed by the resident's legal representative lacked the licensee's license number. On March 24, 2022, at approximately 12:37 p.m., licensed assisted living director (LALD)-E confirmed the license number had not been written on the contract as required. A policy related to the content of the contract was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety or personal property of a resident. This had the potential to	0 970		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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0 970	Continued From page 40 affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's assisted living contract included: - Page 7, section 17. Possession of and Damage to the Apartment. "In the event Provider cannot provide Resident with possession of the Apartment upon the effective date of this Agreement, Resident will not be responsible for the payment of any Monthly Fees until such time as Provider makes the Apartment available to Resident for occupancy. Resident agrees not to hold Provider liable for any damages incurred by Resident as a result of the unavailability of the Apartment. In the event Resident is unable to take possession of the Apartment for any reason other than the unavailability of the same, Resident agrees that Provider is not liable for damages or monetary loss incurred by Resident as a result of Resident's inability to occupy the Apartment on the date anticipated in this Agreement." - Page 7, section 18. Personal Property. "Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal	0 970		

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0 970	Continued From page 41 property due to fire, water, tornado or other acts of nature and events beyond Provider's control. Resident is strongly encouraged to obtain renter's insurance." - Page 7, section 19. Guests. "Resident is responsible for the conduct of Resident's guests and is responsible for any damage they may cause to the Apartment or to the premises of Provider." - Page 9, section 23. 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 live, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents." - Page 10, section 24. Insurance. "Provider will maintain appropriate levels and types of insurance covering the building and its contents. Because Provider does not maintain insurance covering the contents of residents' apartments, or garages, if applicable, Resident is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Apartment, as well as any injury to Resident or Resident's guests occurring within the Apartment ("renter's insurance"). Resident acknowledges and understands that the lack of such insurance coverage may result in personal loss to and/or liability to Resident." - Page 10, section 25. 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	0 970		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 42 result of Provider's own negligent acts or omissions, or those of its employees, officers, manager, 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 March 24, 2022, at approximately 12:25 p.m., licensed assisted living director (LALD)-E verified the licensee's contract included the above language with a waiver. A policy related to the content of the contract was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01420	Continued From page 43 the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-C who performed delegated tasks. 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: ULP-C's record lacked documentation to indicate training and competency testing had been completed for trimming of catheter tubing. ULP-C was hired under the comprehensive home care license on August 3, 2020, and began providing assisted living services on August 1, 2021. On March 23, 2022, at approximately 11:20 a.m., the surveyor observed ULP-C and ULP-D transfer R1 to her wheelchair from bed. R1 was observed	01420		

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01420	Continued From page 44 to have a catheter bag. R1's Resident Notes dated March 21, 2022, authored by ULP-C, noted "staff was checking and changing resident today at 1pm [1:00 p.m.], we had just boosted resident in bed and covering her up when the drain bag tubing and cath [catheter] were noted undone. Immediately attempted to reconnect tubing to cath and was found very loose. I decided to trim back tubing about 1/2 inch, re attached {sp} tubing to cath, little snugger fit. Notified nurse about issue." On March 23, 2022, at approximately 2:40 p.m., ULP-C confirmed she had trimmed the tubing attached to the catheter bag after wiping the bandage scissors and tubing with an alcohol wipe. ULP-C stated this is what the nurse had instructed them to do. On March 24, 2022, at approximately 9:45 a.m., RN-A provided a copy of catheter training she had provided to staff and noted ULP-C had not been present for the training. In addition, RN-A stated the training did not include trimming of the tubing, and it must have been learned before working for the licensee. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted when the RN delegated tasks, prior to the delegation, they must make certain the ULP is trained in the proper methods to perform the tasks of procedures for each client [resident] and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01420		

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01420	Continued From page 45 (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel (ULP)-D with records reviewed.	01440		

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01440	Continued From page 46 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: ULP-D was hired on August 4, 2021, to provide direct care services to residents of the licensee. On March 23, 2022, at approximately 8:18 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record contained a Staff Supervision Summary dated October 8, 2021, (65 days after hire). On March 24, 2022, at approximately 12:22 p.m., regional manager (RM)-B stated ULP-D's first date working alone with residents was August 20, 2021, and verified the supervision was completed more than 30 days after performing delegated tasks. The licensee's Supervision of Personnel - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01440		

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01440	Continued From page 47 (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470		

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01470	Continued From page 48 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees (unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01470		

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01470	Continued From page 49 The findings include: ULP-D was hired on August 4, 2021, to provide direct care services to residents of the licensee. ULP-D's employee record lacked documented evidence of the following: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On March 24, 2022, at approximately 2:30 p.m., regional manager (RM)-B verified ULP-D's record lacked documentation of the required orientation. The licensee's Orientation policy dated July 7, 2020, noted each new team member would be orientated in accordance with State and Federal regulations, and new team members should not perform job duties before the completion of orientation to the job including general and safety orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at	01530		

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01530	Continued From page 50 least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (registered nurse (RN)-A) received the required amount of dementia training, in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01530		

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01530	Continued From page 51 situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the facility did not have a secure dementia unit, but they did have residents with a diagnosis of dementia or Alzheimer's disease. RN-A was hired under the comprehensive home care license on June 14, 2022, and began providing assisted living services and regularly scheduled supervision of direct-care staff on August 1, 2021. RN-A reached 120 working hours on July 5, 2021. RN-A's employee record contained evidence the employee had received 4.5 hours dementia training, less than the required 8 hours within 120 working hours. On March 24, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-E confirmed RN-A had not received the required training in the required time frame. The licensee's Dementia Training policy dated August 1, 2021, noted all personnel would complete 8 hours initial training within 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01620	Continued From page 53 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 admitted to services on February 21, 2022, with diagnoses including major depressive disorder (persistently depressed mood) and diabetes type II (a condition that affects they way the body processes blood glucose). R2's Service Plan dated February 21, 2022, indicated R2 received services including assistance with medication administration and catheter care. R2's record contained an Assessment As Of Date dated February 21, 2022, and March 11, 2022, (18 days after the last assessment). On March 23, 2022, at approximately 3:55 p.m., RN-A confirmed a reassessment had not been done no more than 14 days after initiation of services as required. The licensee's Assessment Schedule Guide policy dated August 1, 2022, noted the resident reassessment and monitoring would be completed no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 54	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01640		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01640	Continued From page 55 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 diagnoses included major depressive disorder and morbid obesity. R2's Service Plan dated February 21, 2021, noted services including assistance with catheter care. The plan was signed by R2, but lacked a signature or other authentication by the facility, documenting agreement on the services to be provided. On March 23, 2022, at approximately 3:55 p.m., registered nurse (RN)-A verified the service plan should be signed by the facility. The licensee's Service Plan policy dated August 1, 2022, noted the service plan and any revision would include a signature or other authentication by the site and by the resident documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01650	Continued From page 56 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01650	Continued From page 57 situation has occurred only occasionally). The findings include: R3's diagnoses included cognitive impairment. R3's Service Plan dated July 20, 2021, noted services including assistance with medication administration and activities of daily living. In addition, the service plan noted "If services to be provided are home care services, an individualized initial assessment will be conducted in person by a registered nurse. This initial assessment will be completed within five days after initiation of home care services." The service plan lacked the schedule of monitoring assessments of the resident to include: - the facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident 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. On March 23, 2022, at approximately 4:10 p.m., registered nurse (RN)-A confirmed the service plan for R3 contained the schedule from the comprehensive license, not the assisted living license regulations. The licensee's Service Plan policy dated August 1, 2022, noted the service plan must include the schedule and method for the next planned assessment or monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for three of three residents (R1, R2 and R3) with records reviewed.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01700	Continued From page 59	01700		

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 the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the licensee provided medication management services to the licensee's residents.

R1, R2, and R3's records lacked evidence the RN had conducted a medication assessment to include:
- identification and review of all mediations the resident was known to be taking;
- indications for medications;
- side effects;
- contraindications; and
- allergic or adverse reactions and actions to address those issues.

R1
R1 had a contract dated August 1, 2021, signed by the resident.

R1's Service Plan dated August 1, 2021, indicated R1 received services including assistance with medication administration and catheter cares.

R1's prescriber orders dated August 17, 2021, included one pain medication and one medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01700	Continued From page 60 for depression. R1's Assessment As Of Date, dated February 14, 2022, noted "ALL MEDICATIONS WERE DISCUSSED WITH RESIDENT." R1's March 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R2 R2 had a contract dated February 21, 2022, signed by the resident. R2's Service Plan dated February 21, 2022, indicated R2 received services including assistance with medication administration, blood glucose and catheter cares. R2's prescriber orders dated March 4, 2022, included, but were not limited to, three medications to lower blood glucose levels and two medications to lower blood pressure. R2's Assessment As Of Date, dated March 11, 2022, noted "Nurse reviews all medications. Staff monitors for medication side effects and any safety concerns, which are reported immediately to licensed staff." R2's March 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R3 R3 had a contract dated August 1, 2021, signed by the resident's representative.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01700	Continued From page 61 R3's Service Plan dated July 20, 2021, indicated R3 received services including assistance with medication administration and activities of daily living. R3's Assessment As Of Date, dated February 15, 2022, noted "Nurse reviews all medications. Staff monitors for medication side effects and any safety concerns, which are reported immediately to licensed staff." R3's prescriber orders dated March 1, 2022, included one medication to increase thyroid levels and one pain medication. R3's March 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On March 23, 2022, at approximately 3:55 p.m., RN-A confirmed the assessment did not contain the above required content, and she was not aware she needed to include all of this in the assessment. The licensee's Medication Management: Assessment, Monitoring & Reassessment policy dated August 1, 2021, noted the assessment must include an identification and review of all medications the resident is known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address those issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01730	Continued From page 62	01730		
01730 SS=E	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 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	01730		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01730	Continued From page 63 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 develop an individualized medication management record with the required content for three of three residents (R1, R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the licensee provided medication management services to the licensee's residents. R1 R1 had a contract dated August 1, 2021, signed by the resident. R1's Service Plan dated August 1, 2021, indicated R1 received services including assistance with medication administration and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01730	Continued From page 64 catheter cares. R1's prescriber orders dated August 17, 2021, included one pain medication and one medication for depression. R1's Assessment As Of Date, dated February 14, 2022, noted a monthly medication exchange from pharmacy, but lacked identification of the person responsible for medication supplies and refills. R1's March 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On March 23, 2022, at approximately 3:34 p.m., registered nurse (RN)-A confirmed R1's record lacked the above required content. R2 R2 had a contract dated February 21, 2022, signed by the resident. R2's Service Plan dated February 21, 2022, indicated R2 received services including assistance with medication administration, blood glucose and catheter cares. R2's prescriber orders dated March 4, 2022, included three medications to lower blood glucose levels and two medications to lower blood pressure. R2's Assessment As Of Date, dated March 11, 2022, noted a monthly medication exchange from pharmacy, but lacked identification of the person responsible for medication supplies and refills. R2's March 2022 Med (Medication) Admin	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01730	Continued From page 65 (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On March 23, 2022, at approximately 3:55 p.m., RN-A confirmed R2's record lacked the above required content. R3 R3 had a contract dated August 1, 2021, signed by the resident's representative. R3's Service Plan dated July 20, 2021, indicated R3 received services including assistance with medication administration and activities of daily living. R3's Assessment As Of Date, dated February 15, 2022, lacked identification of medication management tasks that could be delegated to unlicensed personnel (ULP). R3's prescriber orders dated March 1, 2022, included one medication to increase thyroid levels and one pain medication. R3's March 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On March 23, 2022, at approximately 4:10 p.m., RN-A confirmed R3's record lacked the above required content. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, noted the individual medication management plan would include identification of medication management task that may be delegated to ULP	01730		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 66 and procedures for staff notifying the RN when a problem arose with medication management tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01790	Continued From page 67 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available, with records reviewed.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01790	Continued From page 68 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 22, 2022, at approximately 11:30 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to residents. The licensee's Medication Management: Planned & Unplanned Time Away LOA (Leave of Absence) policy dated August 1, 2021, noted for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate the task to the unlicensed personnel (ULP) if the RN had developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances prescribed for the resident, and the procedures must include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled- the written information about the medications to be given to the resident or resident's representative; - how the ULP must document in the resident's record that medications had been given to the resident or the resident's representative, including documenting the date the medications were given	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01790	Continued From page 69 to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information; - how the RN should be notified that medications had been given to the resident or resident's representative and whether the RN needed to be contacted before the medications were given to the resident or resident's representative; - a review by the RN of the completion of this task to verify the task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication. The licensee's Medication Sent Out of Facility form noted how to document in the electronic medical record system that medications had been sent with the resident but lacked the above required content. On March 24, 2022, at approximately 12:45 p.m., RN-A verified the above required written procedures were not available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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01890	Continued From page 70 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of four residents (R2) with medication storage reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 23, 2022, at approximately 10:10 a.m., the surveyor and unlicensed personnel (ULP)-D complted a review of the locked medication carts. The surveyor observed the following: -R2's Lantus SoloStar prefilled insulin pen was dated as opened March 19, 2022. However, the pen lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been dispensed. On March 23, 2022, at approximately 11:35 a.m., registered nurse (RN)-A verified the insulin should have the original pharmacy label on it.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 71 The licensee's Insulin policy dated August 1, 2021, instructed staff to compare the information on the medication administration record with the label on the medication container, and if unable to read the label, to stop and call the nurse for instructions. The licensee's Medications: Prescription Drugs & Prohibition policy dated August 1, 2021, noted prior to being set up for immediate or later administration, prescription drugs must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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01910	Continued From page 72 (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 document in the resident's record the disposition of the medications as required for one of one resident (R4) upon discharge, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was discharged on February 4, 2022. R4's prescriber orders dated November 23, 2021, included two medications to reduce blood pressure, one medication to assist with low thyroid levels, three medications to assist with depression and anxiety and one medication to help lower cholesterol levels. The resident's Discharge - Transfer Summary dated February 4, 2022, noted medications were sent with R4's family. In addition, the summary	01910		

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01910	Continued From page 73 noted R4 received assistance with activities of daily living and medication management including administration. The summary included a Med (medication) Disposition Summary, which noted disposition of lorazepam (an anti-anxiety medication and controlled substance) to include the date medication name, prescription number, quantity, strength, and names of the staff involved. It noted the mediation was destroyed. On March 22, 2022, at approximately 4:00 p.m., registered nurse (RN)-A stated she had not done disposition for all of R4's medications, but only the one destroyed. RN-A stated she was not aware it was required for all medications. The licensee's Medication Disposal policy dated August 1, 2021, noted upon disposition, the facility must document in the resident's record the disposition including the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and the names of personnel and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 74 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	01940		

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01940	Continued From page 75 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 22, 2022, at approximately 11:30 a.m., regional manager (RM)-B stated the licensee provided treatment management services to the licensee's residents. R2 and R3's records lacked a treatment management plan to include: - procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with treatment or therapy management services. In addition, R2 and R3's service plans lacked a written statement of the treatment services being provided. R2 R2 had a contract dated February 21, 2022, signed by the resident. R2's Service Plan dated February 21, 2022, indicated R2 received services including assistance with medication administration, blood glucose, and catheter cares. However, the service plan lacked identification of continuous positive airway pressure (CPAP) machine. R2's prescriber orders dated March 4, 2022, included CPAP with settings at IPAP 16 cm, BPAP 12 cm. R2's Assessment As Of Date, dated March 11, 2022, lacked procedures for staff notifying an RN	01940		

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01940	Continued From page 76 when a problem arose with treatment management services. On March 23, 2022, at approximately 3:55 p.m., RN-A confirmed R3's record lacked the above required content. R3 R3 had a contract dated August 1, 2021, signed by the resident's representative. R3's Service Plan dated July 20, 2021, indicated R3 received services including assistance with medication administration and activities of daily living. However, R3's record lacked a written statement to include oxygen management. R3's Assessment As Of Date, dated February 15, 2022, lacked procedures for staff notifying an RN when a problem arose with treatment management services. R3's prescriber orders dated March 1, 2022, included if oxygen saturation is below 90% please apply oxygen at 2 liters per minute via nasal cannula. On March 23, 2022, at approximately 4:10 p.m., RN-A confirmed R3's record lacked the above required content. The licensee's Treatment & Therapy: Management Plan policy dated August 1, 2021, noted the treatment and therapy management record must include a statement of the type of services that would be provided and procedures for notifying an RN when a problem arose with treatments or therapy services. No further information was provided.	01940		

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01940	Continued From page 77 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee limited the rights of one of three residents (R3) reviewed when the licensee required the resident or their representative to sign a risk agreement waiving the licensee's liability regarding the use of bedrails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 23, 2022, at approximately 12:05 p.m., the surveyor observed R3's bedrails with registered nurse (RN)-A. R3 had brown metal bilateral quarter bedrails affixed to the bed with 10 vertical bars running from the top bar to the	02290		

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02290	Continued From page 78 bottom bar. R3's diagnoses included cognitive impairment. R3's Negotiated/Shared Risk Agreement - Bed Rail form dated July 26, 2021, included an assessment of the zones of entrapment, identified the use of the bedrails to be for turning and repositioning and included a risk and benefit statement that noted "Bed rails pose a risk of injury including sprains, strains and fractures. Bed rails pose a risk of entrapment which can lead to suffocation and death." In addition, the agreement noted by signing the form, the resident had agreed to bear the risk, whether of personal injury, property damage or loss, or any other consequences which can result by violation of the agreement and/or the resident's behaviors or activities as outlined in the agreement. A policy on waivers of liability was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02310	On March 24, 2022, the immediacy of	

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02310	Continued From page 79 review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of three residents (R1 and R2) with bedrails, with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate correction order on March 23, 2022, related to residents identified as R1 and R2. The findings include: R1 R1's diagnoses included multiple sclerosis and depression. R1's Service Plan dated August 1, 2021, noted services including assistance with activities of daily living and transferring. R1's Negotiated/Shared Risk Agreement-Bed Rail dated March 23, 2022, identified "Resident wishes to use a bed rail for turning and repositioning." It also noted, "Bed rails pose a risk of injury including sprains, strains and fractures. Bed rails pose a risk of entrapment which can lead to suffocation and death." On March 23, 2021, at approximately 10:55 a.m., registered nurse (RN)-A verified an assessment	02310	correction order 2310 was removed, however non-compliance remained at a scope and level of G.	

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02310	Continued From page 80 of R1's bedrails including measurements and risk versus benefits had not been completed and stated she had just measured the bedrails during the survey. The measurements included: - zone 1: 3 1/4 inches - zone 2: 2 inches - zone 3: 1 1/2 inches - zone 4: 2 inches On March 23, 2022, at approximately 11:50 a.m., RN-A confirmed an assessment with measurements and risk versus benefits had not been completed for R1 before today. R2 R2's diagnoses included major depressive disorder and morbid obesity. R2's Service Plan dated February 21, 2021, noted services including assistance with catheter care. R2's Negotiated/Shared Risk Agreement-Bed Rail dated March 22, 2022, identified the resident, "wishes to use a bed rail for turning and repositioning." It also noted, "Bed rails pose a risk of injury including sprains, strains and fractures. Bed rails pose a risk of entrapment which can lead to suffocation and death." On March 23, 2022, at approximately 9:25 a.m., RN-A verified R2's assessment including measurements of the bedrails and risk versus benefits had not been completed before March 22, 2022, during the survey. RN-A stated the measurements for R2's bedrails fall within the FDA guidelines. In addition, RN-A confirmed the licensee's policy indicated an assessment should be completed of bedrails when they are present.	02310		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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02310	Continued From page 81 On March 23, 2022, at approximately 12:05 p.m., the surveyor observed RN-A measure R2's bedrails. R2's bed was observed to be a hospital bed with bilateral quarter bedrails affixed to the bed. Measurements included: - zone 1: 4 1/4 inches - zone 2: 1/2 inch - zone 3: tight - zone 4: 1/2 inch The licensee's Side Rails policy dated August 1, 2021, noted when bedrails are in use, the RN must conduct an assessment of the purpose and risks of the bedrails, and verify the bedrails are within FDA recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA recognizes that zones 6 and 7 present a risk of either neck or chest entrapment and acknowledge that this space may change when raising or lowering the head or foot sections of the bed. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems	02310		

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02310	Continued From page 82 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." TIME PERIOD FOR CORRECTION: Immediate *UPDATE* On March 24, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03000 SS=E	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	03000		

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03000	Continued From page 83 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for three of three residents (R3, R7 and R8) with records reviewed.	03000		

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03000	Continued From page 84 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 22, 2022, at approximately 11:30 a.m., a request was made to regional manager (RM)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2022. On March 23, 2022, the surveyor received an anonymous complaint of the following: - R3 reported staff had flicked her nose with their fingers over the weekend; - R7 reported staff on the night shift pulled the walker away from him, putting it too far in front of him when he was trying to walk; and - R8 was found on the floor when the day staff went in to provide medication administration. R3 R3 admitted to the facility on July 20, 2021, with diagnoses including cognitive impairment. R3's Service Plan dated July 20, 2021, indicated R3 received services including assistance with medication administration and activities of daily living. R3's Assessment As Of Date, dated February 15, 2022, noted R3 was at risk to be abused.	03000		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

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03000	Continued From page 85 R3's Resident Notes from January 22, 2022, through March 22, 2022, lacked information on the incident. R7 R7 admitted to the facility on August 9, 2021, with diagnoses including cerebral infarction, difficulty walking, and muscle weakness. R7's Service Plan dated December 17, 2021, indicated R7 received services including assistance with medication administration and activities of daily living. R7's Assessment As Of Date dated February 15, 2022, noted R7 was at risk to be abused, and staff were to perform nightly safety checks, encourage to perform activities of daily living, and provide time to express himself. R7's Resident Notes from February 1, 2022, through March 24, 2022, lacked information on the incident. R8 R8 admitted to the facility on August 19, 2020, with diagnoses including chronic pain and mild dementia. R8's Service Plan dated August 1, 2021, indicated R8 received services including assistance with medication administration, positioning and transfers. R8's Assessment As Of Date dated February 14, 2022, noted R8 was at risk to be abused, and indicated R8 required assistance to be turned and repositioned.	03000		

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	30568	A. BUILDING: _____ B. WING _____	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 COUNTY ROAD 9 HERON LAKE, MN 56137

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03000	Continued From page 86 R8's Resident Notes dated March 12, 2022, included a note authored by registered nurse (RN)-A that noted "Staff called this writer and stated that pt. [patient] was found on bedside matt [sic] on floor next to pt's bed. Pt. was c/o [complaining of] pain in various areas. Directed staff to call pt's daughter and send pt. to ER [emergency room] to be checked out. Ambulance was called and pt. was sent to the ER. Pt. later returned with findings of UTI [urinary tract infection], and instructions to ice swollen/painful areas on and off over next days. Pt. was also started on Cipro 250mg [250 milligrams] by mouth two times per day for UTI." The Continued Investigation typed document, unsigned, and dated March 16, 2022, noted the following: - Asked staff to show how R8's bed pressure alarm worked. All attempts to get the alarm to work failed, even though it had been reported to be working earlier in that day. - Visited R3 asking if there was trouble over the weekend. Resident reported she missed her loved ones and became teary eyed. R3 also stated staff wanted her to go to bed at 7:30 p.m., but she wanted to go to bed at 9:30 p.m. When asked if staff had flicked or poked at her nose, R3 denied, but stated they had tapped her nose while stating "listen to us; we know what we are doing." R3 added staff stated this when they were telling her it was time to go to bed at 7:30 p.m. - Visited R7 to ask if there was any trouble with staff over the weekend. R7 stated yes, he had been looking for staff to help him to the bathroom, but didn't see anyone around, so he wheeled his wheelchair in front of the bathroom door, and self-transferred to the toilet. Staff then barged into his room and began hollering at him "you can't do this by yourself!" and attempted to pull the	03000		

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03000	Continued From page 87 wheelchair away, but R7 grabbed it and said he was stronger than the staff, who let the chair go. He was then assisted to the recliner or bed and noticed his footrests were missing from his wheelchair. R7 stated "that night crew, they are directly to the point and mean." On March 24, 2022, at approximately 10:32 a.m., regional manager (RM)-B stated she received a text while on vacation of the concerns from March 12, 2022, and asked staff to reach out to the nurse on call, registered nurse (RN)-A. Also at approximately 10:32 a.m., RN-A stated she was contacted by staff on March 12, 2022, and RN-A stated she emailed the corporate RN, licensed assisted living director (LALD)-E, and RM-B with concerns immediately, and the corporate RN informed her an investigation would need to be completed. In addition, RN-A confirmed she did not complete the investigation with any of the three residents until March 16, 2022, four days later. RM-B stated the concerns should have been reported to MAARC if deemed suspicious, and confirmed the three reports were suspicious. However, the licensee made no reports to MAARC. The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, noted team members who suspect maltreatment of a resident would contact the assisted living director, and if they confirmed the suspicion of maltreatment would contact MAARC no more than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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03030 SS=E	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report	03030		

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03030	Continued From page 89	03030		

an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for three of three residents (R3, R7 and R8) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on March 22, 2022, at approximately 11:30 a.m., a request was made to regional manager (RM)-B to review all vulnerable adult reports the licensee had made to MAARC since August 1, 2022.

On March 23, 2022, the surveyor received an anonymous complaint of the following:
- R3 reported staff had "flicked" her nose with their fingers over the weekend;
- R7 reported staff on the night shift pulled the walker away from him, putting it too far in front of him when he was trying to walk; and
- R8 was found on the floor when the day staff went in to provide medication administration.

R3
R3 admitted to the facility on July 20, 2021, with diagnoses including cognitive impairment.

R3's Service Plan dated July 20, 2021, indicated R3 received services including assistance with

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03030	Continued From page 90 medication administration and activities of daily living. R3's Assessment As Of Date, dated February 15, 2022, noted R3 was at risk to be abused. R3's Resident Notes from January 22, 2022, through March 22, 2022, lacked information on the incident. R7 R7 admitted to the facility on August 9, 2021, with diagnoses including cerebral infarction, difficulty walking, and muscle weakness. R7's Service Plan dated December 17, 2021, indicated R7 received services including assistance with medication administration and activities of daily living. R7's Assessment As Of Date dated February 15, 2022, noted R7 was at risk to be abused, and staff were to perform nightly safety checks, encourage to perform activities of daily living, and provide time to express himself. R7's Resident Notes from February 1, 2022, through March 24, 2022, lacked information on the incident. R8 R8 admitted to the facility on August 19, 2020, with diagnoses including chronic pain and mild dementia. R8's Service Plan dated August 1, 2021, indicated R8 received services including assistance with medication administration, positioning and transfers.	03030		

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03030	Continued From page 92 but didn't see anyone around, so he wheeled his wheelchair in front of the bathroom door, and self-transferred to the toilet. Staff then barged into his room and began hollering at him "you can't do this by yourself!" and attempted to pull the wheelchair away, but R7 grabbed it and said he was stronger than the staff, who let the chair go. He was then assisted to the recliner or bed and noticed his footrests were missing from his wheelchair. R7 stated "that night crew, they are directly to the point and mean." On March 24, 2022, at approximately 10:32 a.m., regional manager (RM)-B stated she received a text while on vacation of the concerns from March 12, 2022, and asked staff to reach out to the nurse on call, registered nurse (RN)-A. Also at approximately 10:32 a.m., RN-A stated she was contacted by staff on March 12, 2022, and RN-A stated she emailed the corporate RN, licensed assisted living director (LALD)-E, and RM-B with concerns immediately, and the corporate RN informed her an investigation would need to be completed. In addition, RN-A confirmed she did not complete the investigation with any of the three residents until March 16, 2022, four days later. RM-B stated the concerns should have been reported to MAARC if deemed suspicious, and confirmed the three reports were suspicious. However, the licensee made no reports to MAARC. The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, noted team members who suspect maltreatment of a resident would contact the assisted living director, and if they confirmed the suspicion of maltreatment would contact MAARC no more than 24 hours after the maltreatment was first suspected.	03030		

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03030	Continued From page 93 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03030		

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

Type: Full
Date: *03/24/22*
Time: 10:15:26
Report: 1020221035

Food and Beverage Establishment Inspection Report

Location:
Lakeview Assisted Living
941 County Road 9
P.O. Box 197
Heron Lake, MN56137
Jackson County, 32

Establishment Info:
ID #: 0023345
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Lakes Communities, Inc.

Phone #: 5077932349
ID #: 29672

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.

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLES OF SANITIZER UNLABELED. DISCUSSED WITH PERSON IN CHARGE. SPRAY BOTTLES WERE LABELED.

Corrected on Site

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO KNOWN CERTIFIED FOOD PROTECTION MANAGER. FACT SHEET AND ADDITIONAL INFORMATION ON CERTIFIED FOOD PROTECTION MANAGER PROVIDED WITH THE REPORT.

Comply By: 05/31/22

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

BAGS OF MASHED POTATOES THAWING IN A TUB IN THE PREP SINK IN STAGNANT WATER. DISCUSSED THAWING PROCESSES WITH PERSON-IN CHARGE.

Comply By: 03/24/22

4-200 Equipment Design and Construction

4-201.11AMN

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

DOMESTIC CROCKPOT AND WAFFLE MAKER BEING USED AT THE ESTABLISHMENT; REPLACE WITH ANSI CERTIFIED EQUIPMENT.

Comply By: 06/01/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER BOTTLE
Violation Issued: No

Wash Temperature Gauge: = at 154 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Final Rinse Temperature Ga: = at 181 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Utensil Surface Temperatur: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: SLOPPY JOES - WALK-IN COOLER
Violation Issued: No

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

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: HAMBURGER - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - CHEST FREEZER
Violation Issued: No

Process/Item: Cooking
Temperature: 182 Degrees Fahrenheit - Location: STEAK - FLAT TOP GRILL
Violation Issued: No

Type: Full
Date: *03/24/22*
Time: 10:15:26
Report: 1020221035
Lakeview Assisted Living

Food and Beverage Establishment Inspection Report

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

GENERAL COMMENTS:

DISCUSSED CURRENT COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG AND ILLNESS REPORTING REQUIREMENTS FACT SHEET PROVIDED WITH THE REPORT.

DISCUSSED THAWING, COOLING, AND RE-HEATING PROCESSES. FACT SHEET ON COOLING PROVIDED WITH THE REPORT.

TEMPERATURE LOGS USED FOR COOLER AND STEAM TABLE. UPDATE LOG FOR DISHWASHER TO INCLUDE WASH TEMPERATURE, RINSE TEMPERATURE, AND UTENSIL SURFACE TEMPERATURE.

THE WALK-IN FREEZER IS CURRENTLY NON-FUNCTIONAL AND IS NOT IN USE. A CHEST FREEZER IS CURRENTLY BEING USED.

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 1020221035 of 03/24/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: Report emaikd
Establishment Representative

Signed: Ashley R
Ashley B

651-201-4500

Report #: 1020221035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	Date	03/24/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:15:26
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Lakeview Assisted Living	941 County Road 9	Heron Lake, MN	56137	5077932349

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0023345	Lakes Communities, Inc.	Full		H

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	X	
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) Report emaild **Date:** 03/30/22

Inspector (Signature)