Electronically Delivered

August 2, 2022

Administrator
Osseo Gardens Assisted Living
525 2nd Street Southeast
Osseo, MN 55369

RE: Project Number(s) SL21206015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 20, 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, no immediate fines are assessed.

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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

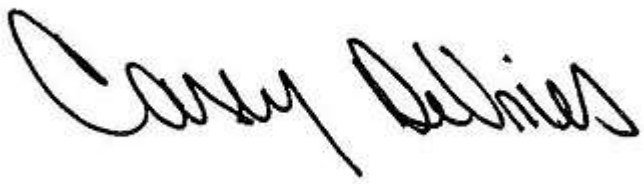
St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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
State Evaluation Team
Health Regulation Division
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
	21206	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21206015-0 On July 18, 2022, through July 20, 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 32 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 1 (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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all 32 residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485		

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0 485	Continued From page 2 On July 18, 2022, at approximately 11:44 a.m., during a facility tour, the surveyor observed the undated menu on s bulletin board titled Menu. The observed menu was not prepared at least one week in advance. On July 18, 2022, at 12:04 p.m., administrator (A)-C verified the menu was not prepared at least one week in advance and made available to all residents. A-C stated the chef created a weekly menu and posted menu on bulletin board for residents to view. The licensee's Food Service & Menu Planning policy dated August 1, 2021, indicated the licensee would prepare menu at least one week in advance and menu would be available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community	0 490		

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0 490	Continued From page 3 resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all 32 residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2022, at approximately 11:42 a.m., during a facility tour, the surveyor observed a white board that included an activity of candy bar	0 490		

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0 490	Continued From page 4 bingo. On July 18, 2022, at approximately 11:58 a.m., the surveyor observed a document titled Garden Gazette dated July 2022. The document included activities Monday through Friday however, lacked activities on Saturday and Sunday. On July 18, 2022, at 11:58 a.m., administrator (A)-C verified the licensee lacked a daily program of social and recreational activity. A-C stated the licensee provided social and recreational activities Monday through Friday and social and recreational activities were not offered to the residents on Saturday and Sunday. In addition, A-C stated the licensee used to provide activities on Saturday and Sunday for residents however, due to low resident participation, the licensee stopped activity programming on Saturday and Sunday. The licensee's Activity Programming policy dated August 1, 2021, indicated the licensee would provide activities and social recreation for residents. In addition, the licensee would create a monthly activity calendar that would be made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 5 (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 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all 32 residents receiving services under the assisted living license. 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	0 680		

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0 680	Continued From page 6 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - the specific name/location of the receiving facility or other location; - names and contact information of residents' physicians, other facilities, volunteers; and - emergency prep testing requirements. On July 19, 2022, at 1:10 p.m., registered nurse (RN)-A stated the licensee had their first fire drill with the fire chief and planned to have an evacuation drill in the future. In addition, RN-A stated the licensee's quality management team was working on the EPP which included drills. On July 19, 2022, at approximately 1:45 p.m., administrator (A)-C stated the licensee had contacted facilities to provide temporary shelters in case of an evacuation, however, have not had a response from the facilities. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would conduct a minimum of two emergency preparedness drills every six months which would include fire and evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 7	0 780		
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: Based on observation and interview, the licensee failed ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 780		

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0 780	Continued From page 8 cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 07/19/2022, between 09:20 am and 11:30am, survey staff toured the facility with HM-. During the facility tour, survey staff observed smoke alarms were not interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. HM- verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 810		

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0 810	Continued From page 9 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: 0810 Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 07/19/2022, from approximately 0930 to 1130,	0 810		

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0 810	Continued From page 10 survey staff toured the facility with HM. During the facility tour, survey staff observed the facility only conducted fire drill on April 6,2022 at 12pm HM verbally confirmed survey staff observations during the facility tour. During interview on 0719/2022 at 1130, LALD-C stated she has just started at the facility and could not find reports of past fire drills. Survey staff requested fire safety training and evacuation plan documentation, but the licensee did not provide the requested documentation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days or Twenty-one (21) days	0 810		
01720 SS=F	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion 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 discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for one of five residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01720		

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01720	Continued From page 11	01720		

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

The findings include:

R5 began receiving services on October 5, 2015, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R5's diagnoses included Parkinson's disease and edema.

R5's Service Plan - Addendum to Contract dated September 4, 2021, indicated R5 received services including medication assistance, vital signs, safety check, shopping assist, thromboembolism-deterrent (TED) stockings, toileting, bathing, dressing, grooming, housekeeping, behavior management, and activity assistance.

On July 19, 2022, at approximately 8:40 a.m., the surveyor observed R5 refuse furosemide (a medication that is known as a diuretic. It helps your body get rid of extra water by increasing the amount of urine you make. Getting rid of extra water decreases the strain on your heart and blood vessels, thereby lowering high blood pressure and reducing your risk of stroke, heart attack and kidney problems) 40 milligrams (mg). Unlicensed personnel (ULP)-B did not provide education to R5 about the refusal of the furosemide. In addition, ULP-B documented "refused" on furosemide 40 mg in the electronic

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	21206	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(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
01720	Continued From page 12	01720		

medication administration record (EMAR) and did not provide a reason for refusal.

On July 19, 2022, at approximately 8:45 a.m., the surveyor observed edema to R5's lower extremities and shortness of breath while R5 ambulated.

R5's EMAR dated July 2022 indicated R5 refused furosemide 40 mg nine times in the month of July. In addition, the EMAR indicated the reason for refusal of furosemide 40 mg was refused. The EMAR lacked reason for refusal and education provided to the resident by the staff.

R5's Resident Notes dated June 1, 2022, to July 19, 2022, lacked documentation of education provided to resident by staff on refusal of furosemide 40 mg.

On June 20, 2022, at 10:07 a.m., ULP-D stated when a resident refused medication staff would tell resident to take medication because "this will help you." In addition, ULP-D stated staff would update the nurse on the medication refusal.

On June 20, 2022, at 10:36 a.m., registered nurse (RN)-A stated ULP's would educate residents on possible consequences when a medication was refused however, the licensee did not have a system or protocol for documenting education that would be provided to all resident for refusal of medications or treatments. In addition, RN-A stated RTasks (an electronic medical documentation system) would alert nurses to any medications refused by residents.

The licensee's Medication & Treatment Record-Documentation & Refusals dated August 1, 2021, indicated the licensee would discuss with

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	21206	A. BUILDING: _____ B. WING _____	07/20/2022

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01720	Continued From page 13 the resident the possible consequences of the resident's refusal and document the discussion in the resident medical record. In addition, the licensee would include the reason why a medication or treatment was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications and to discard expired medication for four of 15 residents (R3, R7, R8, R9) 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 a widespread scope (when	01890		

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01890	Continued From page 14	01890		

problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On July 19, 2022, at approximately 7:45 a.m., the surveyor observed one of the two medication carts at the facility. The medication cart included the following expired medications and medications lacking a prescription label with legible information including expiration date for time sensitive medication:
- R3's acetaminophen 500 milligrams (mg) with expiration date June 22, 2021;
- R3's docusate sodium 100 mg with expiration date of June 22, 2021;
- R3's ondansetron 4 mg with expiration date of April 6, 2022;
- R7's polyvinyl 0.4 percent (%) lacked date open label;
- R8's Cetaphil liquid cleanser with expiration date of June 16, 2022;
- R9's Dorzolamide-Timolol solution 22.3 mg-6.6 mg eye drop lacked date open label;
- unknown resident Diclofenac sodium topical gel with illegible prescription label; and
- unknown resident hydrocortisone cream 1 % with illegible prescription label.

On July 19, 2022, at 10:13 a.m., registered nurse (RN)-A stated medication carts were checked for expired medications and labeling every 28 days with the pharmacy cycle fill of medications. In addition, RN-A stated time sensitive medication were labeled with the date opened and medication would have legible prescription labels.

On July 19, 2022, at 10:23 a.m., RN-A stated as needed (PRN) medications and narcotics

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01890	Continued From page 15 potentially were not checked for labeling and would be destroyed if expired when cycle fill occurred. In addition, RN-A stated they would complete education to the unlicensed personnel on labeling and expired medication on July 19, 2022. The licensee's Medication Disposal policy dated August 1, 2021, indicated the licensee would dispose expired medications to the accepted practices of the Minnesota Board of Pharmacy. The licensee's Medication-Prescription Drugs & Prohibition policy dated August 1, 2021, indicated a prescription drug would bear the original prescription label with legible information which included expiration or beyond-use date of a time-dated drug. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01970		

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01970	Continued From page 16	01970		

review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of four residents (R5) receiving treatments.

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

The findings include:

On July 19, 2022, at approximately 8:51 a.m., the surveyor observed unlicensed personnel (ULP)-B apply tubigrip (multi-purpose tubular bandage designed to provide tissue support in treating general edema/swelling) from R5's feet to just below the knees.

R5's diagnoses included Parkinson's disease and edema.

R5 Service Plan - Addendum to Contract dated September 4, 2021, indicated R5 received services including medication assistance, vital signs, safety check, shopping assist, thromboembolism-deterrent (TED) stockings, toileting, bathing, dressing, grooming, housekeeping, behavior management and activity assistance.

R5's physician order dated August 3, 2020, included compression stockings knee high 30 to 40 millimeters of mercury (mm/hg) for edema (swelling caused by excess fluid accumulation in

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	21206	A. BUILDING: _____ B. WING _____	07/20/2022

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01970	Continued From page 17 the body tissues). R5's physician order dated January 21, 2022, included daily ACE wraps provided by home care. R5's physician order dated May 11, 2022, included lower extremity velcro wrap for legs, to be worn daily. R5's RTasks (an electronic medical documentation system) service tasks dated July 20, 2022, indicated ULP's were to apply TED stockings in the morning and remove TED stockings in the evening. On July 19, 2022, at approximately 8:51 a.m., ULP-B stated TED stockings were not used on R5 because R5 could not fit the TED stocking. In addition, ULP-B stated R5 used tubigrip every morning. On July 19, 2022, at approximately 12:55 p.m., registered nurse (RN)-A stated R5 was receiving tubigrip in the morning until home care received the velcro wraps. On July 20, 2022, at 10:59 a.m., RN-A stated nurses transcribe orders when received. In addition, RN-A stated the tasks for ULP's were created by the service plans in RTasks and when a nurse updated the service plan with a new treatment it would generate a new task for the ULP's to complete on the residents. On July 20, 2022, at approximately 11:04 a.m., licensed practical nurse (LPN)-F stated if home care services were involved with a resident treatment, the licensee would not compete nursing tasks until home care discharged. The surveyor asked why the ULP applied tubigrip to	01970		

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01970	Continued From page 18 the lower extremities (part of the body that includes the leg, ankle or foot) on R5 when the task read to apply TED stockings? LPN-F stated the order for TED stockings should have been placed on hold. In addition, LPN-F stated home care had the applied tubigrip and were waiting for velcro wraps to arrive. The licensee's Medication & Treatments policy dated August 1, 2021, indicated current prescriber orders would be obtained for any treatment provided to a resident. In addition, the nurse would review all treatment orders, medication administration record (MAR), and treatment administration record (TAR) for progress, effectiveness on a regular basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted	02410		

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02410	Continued From page 19	02410		

in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.
(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration for one of five residents (R10) observed during medication administration.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 July 19, 2022, at 8:26 a.m., the surveyor observed unlicensed personnel (ULP)-B administer prednisolone suspension 1 percent (%) eye drop to R10 in the dining area with other residents present. R10 was not asked location preference for medication administration by ULP-B.

On July 20, 2022, at 10:09 a.m., ULP-D stated

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02410	Continued From page 20 staff were to ask residents where they preferred to take medication. In addition, ULP-D stated some residents prefer to receive eye drops in common areas and some residents prefer privacy. On July 20, 2022, at 10:54 a.m., registered nurse (RN)-A stated staff were trained to administer creams, nebulizers, eye drops and insulins in resident rooms. In addition, RN-A stated pill form medication can be administered where the resident prefers. The licensee's Eye Drop and Eye Ointment policy dated August 1, 2021, indicated staff would provide privacy for the individual during eye drop or eye ointment administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *07/18/22*
Time: 10:00:00
Report: 8087221170

Food and Beverage Establishment Inspection Report

Location:
Osseo Gardens Assisted Living
525 2nd Street Se
Osseo, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0037565
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633154869
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Chlorine: = 100 PPM at 124 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 11 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

Process/Item: Cold Holding: GROUND BEEF
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

Type: Full
Date: *07/18/22*
Time: 10:00:00
Report: 8087221170
Osseo Gardens Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: MILK
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSING EVALUATOR ASHLEY CREWS.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

3 HAND WASHING SINKS LOCATED IN KITCHEN ARE MADE OF CERAMIC AND ARE NOT APPROVED. MAGNETIC KNIFE RACK IS MADE OF WOOD AND IS NOT APPROVED.

INSPECTION REPORT EMAILED TO NURSING EVALUATOR ASHLEY CREWS.

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 8087221170 of 07/18/22.

Certified Food Protection Manager: MOHAN D. RAM

Certification Number: FM24496 Expires: 08/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
MOHAN D. RAM
KITCHEN MANAGER

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us