DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 18, 2022

Administrator
Central Minnesota Senior Care
1008 South 10th Street
Brainerd, MN 56401

RE: Project Number(s) SL20683015

Dear Administrator:

On October 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 27, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

Electronically Delivered

August 10, 2022

Administrator
Central Minnesota Senior Care
1008 South 10th Street
Brainerd, MN 56401

RE: Project Number SL20683015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 27, 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 - $500.00

The total amount you are assessed is $500.00. 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 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

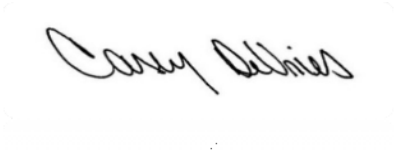
REQUESTING A HEARING

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
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St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(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, these correction orders have 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: SL20683015-0 On July 25, 2022, through July 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were eight residents receiving services under the 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 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 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all eight 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	0 470		

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0 470	Continued From page 2	0 470		

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

The findings include:

The licensee held an assisted living license and was licensed for a capacity of 11 residents. The licensee had a current census of eight residents.

The licensee failed to develop and implement a staffing plan for determining its staffing level that:
- included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;
- ensured 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
- ensured the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.

On July 25, 2022, at approximately 10:25 a.m., during the facility tour, the surveyor noted the facility did not have a staffing plan or staffing schedule posted in an area accessible to residents or visitors. A staff schedule was later pointed out by administrator (A)-E to the surveyor and had been posted in the manager's locked office.

On July 27, 2022, at approximately 10:15 a.m., during the exit conference, A-E provided a document to the surveyor titled Staffing Plan. The

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0 470	Continued From page 3 document consisted of instructions for the registered nurse to follow to create a staffing plan. A-E confirmed the staff schedule observed by the surveyor was posted on the manager office wall and was the only document pertaining to staffing and confirmed the registered nurse had not developed a written staffing plan to include the above noted required content. Additionally, A-E stated, " we are trying to figure out different things." The licensee's Staffing Plan policy dated February 24, 2022, indicated the clinical nurse supervisor would develop a 24-hour daily staffing schedule that would include staff work schedules, days and hours worked and resident assignments or work location. The daily work schedule would be posted at the beginning of each shift in a central location and an evaluation of the staffing plan would be conducted at least twice a year. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480		

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0 480	Continued From page 4 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all eight 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 included document titled, Food and Beverage Establishment Inspection Report dated July 25, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 5 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure employees wore recommended personal protective equipment while working in the facility providing direct resident cares and failed to COVID-19 screen employees or visitors entering the facility. The deficient practice had the potential to affect all residents, employees 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: On July 25, 2022, at 10:00 a.m., a surveyor from the Minnesota Department of Health (MDH)	0 510		

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0 510	Continued From page 6	0 510		

entered the facility. The surveyor completed a COVID-19 self-screen document and requested a thermometer from unlicensed personnel (ULP)-D. The COVID-19 screening area located at the entrance door lacked a thermometer.

EYE PROTECTION
ULP-D
On July 25, 2022, at approximately 10:30 a.m., the surveyor toured the facility with ULP-D. ULP-D wore a medical grade mask, prescription eyeglasses and no protective eyewear throughout the tour. At approximately 11:32 a.m., the surveyor observed ULP-D conduct a glucose (sugar) check for R1. ULP-D wore a medical grade mask, prescription eyeglasses and no protective eyewear. Throughout the remainder of the day on July 25, 2022, and throughout the day on July 26, 2022, the surveyor observed ULP-D conduct various tasks for residents of the facility wearing a medical grade mask, prescription eyeglasses and no protective eyewear.

ULP-C
On July 25, 2022, at approximately 11:45 a.m., the surveyor observed ULP-C prepare lunch and plate setup for residents in the facility dining room with five residents present. ULP-C wore a medical grade mask and no protective eyewear. Throughout the remainder of the day on July 25, 2022, the surveyor observed ULP-C interact with residents wearing a medical grade mask and no protective eyewear. On July 26, 2022, at approximately 11:55 a.m., the surveyor observed ULP-C administer R2's noon medications to include a Novolog insulin injection. ULP-C wore a medical grade mask and no protective eyewear.

STAFF COVID-19 SCREENING
On July 26, 2022, at approximately 1:30 p.m., the

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0 510	Continued From page 7 surveyor reviewed the licensee's July COVID-19 staff screening logs provided to the surveyor by administrator (A)-E. Two staff work the 6:00 a.m. to 2:00 p.m. shift, two staff work the 2:00 p.m. to 10:00 p.m. shift and 1 staff works the 10:00 p.m. to 6:00 a.m. shift. All shifts reviewed by the surveyor had staff who failed to complete a COVID-19 screening prior to their shifts on the following dates during July 2022: - July 1: 2 of 5 staff failed to COVID-19 screen; - July 2: 2 of 5; - July 3: 3 of 5; - July 4: 3 of 5; - July 5: 3 of 5; - July 6: 1 of 5; - July 7: 2 of 5; - July 8: 1 of 5; - July 9: 2 of 5; - July 10: 3 of 5; - July 11: 2 of 5; - July 12: 2 of 5; - July 13: 2 of 5; - July 14: 5 of 5; - July 15: 3 of 5; - July 16: 2 of 5; - July 17: 2 of 5; - July 18: 3 of 5; - July 19: 4 of 5; - July 20: 3 of 5; - July 21: 4 of 5; - July 22: 2 of 5; - July 23: 3 of 5; - July 24: 5 of 5; and - July 25: 3 of 5. During an interview on July 27, 2022, at 10:15 a.m., licensed assisted living director (LALD)-A confirmed the lack of protective eyewear use for ULP-C and ULP-D and the lack of staff	0 510		

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0 510	Continued From page 8 COVID-19 screening. LALD-A stated "staff and visitors are supposed to come to the door and staff are supposed to screen them, but sometimes our families are so comfortable they just walk in." Clinical nurse supervisor (CNS)-F stated, "they know they are supposed to screen." Additionally, A-E stated, "that is definitely something we can work on, we are aware of what we need to do." The surveyor confirmed with A-E and LALD-A the link to the Centers for Disease Control and Prevention (CDC) website for knowledge of community transmission levels and required personal protective equipment (PPE) use. A-E stated "yes, we are familiar with the COVID-19 Tracker site." The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated April 7, 2022, indicated with high community transmission levels, protective eyewear and medical grade masks were to be worn by staff to prevent unseen spread of COVID-19 in a facility. The guidance recommended eye protection when staff were in resident care areas. The surveyor, LALD-A and A-E confirmed the county level to be high. VISITOR SCREENING On July 25, 2022, at approximately 11:30 a.m., the surveyor observed a fire system technician walking throughout the building, in and out of resident's rooms, hallways, dining area and working within resident areas with residents present. The technician wore a medical grade mask, no protective eyewear. On July 26, 2022, at approximately 9:20 a.m., the surveyor observed a physical therapist assisting a resident with ambulation. The physical therapist	0 510		

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0 510	Continued From page 9 wore a medical grade mask, no protective eyewear. On July 27, 2022, at approximately 10:00 a.m., the surveyor reviewed the COVID-19 visitor screening log. Neither the fire system technician nor the physical therapist had completed a COVID-19 screening prior to working in direct contact with the licensee's residents. The licensee's Prevention of Transmission of Communicable Disease with Specific Protocol for Prevention of Transmission of COVID-19 policy dated July 21, 2020, indicated all staff would screen for fever or symptoms prior to starting each shift and would conduct COVID-19 screenings on other health care personnel to include therapy personnel and state surveyors. In addition, staff would wear a mask at all times in the facility, wear eye protection during all resident care encounters and provide instruction to all visitors before visitors enter the facility on hand hygiene, symptoms of COVID-19, use of personal protective equipment (PPE) and the facility would communicate this to visitors through multiple means such as signage at entrances, emails, phone calls and recorded messages. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	0 550		

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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
0 550	Continued From page 10 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 and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all eight 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 July 25, 2022, during the facility tour at approximately 10:30 a.m., the surveyor observed facility common areas and noted the lack of required posting of the licensee's grievance procedure and information related to reporting suspected maltreatment to MAARC. In addition, there was no posting of the contact information for the state and applicable regional Office of	0 550		

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	20683	A. BUILDING: _____ B. WING _____	07/27/2022

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0 550	Continued From page 11 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to MAARC. On July 27, 2022, at approximately 10:00 a.m., administrator (A)-E confirmed the content noted above was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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 post the required information to include: (1) Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) Posting information and the reporting number	0 640		

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0 640	Continued From page 12 for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all 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) 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 lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. On July 25, 2022, at approximately 10:30 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-D and observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. ULP-D confirmed the 911 number and MAARC information was not posted. On July 27, 2022, at approximately 10:00 a.m., administrator (A)-E confirmed the 911 emergency number was not posted on or near the telephone located on a counter in the main area and the contact information or reporting number for MAARC was not posted. No further information was provided.	0 640		

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0 640	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). Additionally, the licensee failed to ensure it completed a facility TB risk assessment or identify a person in charge of the TB infection control program. 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	0 660		

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0 660	Continued From page 14	0 660		

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:

TB RISK ASSESSMENT

On July 25, 2022, at approximately 1:50 p.m., the surveyor requested the facility's TB risk assessment. Administrator (A)-E provided a Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) dated March 10, 2020. A-E stated she thought the facility had completed a recent TB risk assessment, however, the risk assessment provided for review was not current.

On July 27, 2022, at approximately 10:20 a.m., the surveyor asked clinical nurse supervisor (CNS)-F if she was aware of the TB risk assessment requirement and the TB risk assessment provided was not current. CNS-F stated, "that was an oversight and a change in the person that oversaw that."

The licensee's TB policy dated July 2013 was the Regulations for Tuberculosis Control in Minnesota Health Care Settings regulation guidebook and indicated the facility would update their TB risk assessment every other year and would observe the recommended precautions related to TB prevention identified by the CDC and MDH to include the precautionary element of completing a TB risk assessment.

The MDH guidelines, "Regulations for

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0 660	Continued From page 15 Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment and update their TB risk assessment every other year. 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 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.	0 680		

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0 680	Continued From page 16 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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: During the facility tour with unlicensed personnel (ULP)-D on July 25, 2022, at approximately 10:30 a.m., the surveyor observed the facility's layout included the main entrance, a large common area, dining room, two hallways that provided access to resident rooms, a laundry room and managerial/nursing office. There were emergency exit diagrams in the main entry, dining room, laundry room and resident rooms. There was no evidence of the emergency disaster plan posted prominently, as required. On July 27, 2022, at approximately 10:00 a.m., administrator (A)-E confirmed the emergency disaster plan was not posted prominently. A-E stated the emergency preparedness binders were kept in the locked managers office.	0 680		

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0 680	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2022, between 11:20 a.m. and 12:20 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the	0 800		

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0 800	Continued From page 18 following: 1. On the outdoor patio, staples were used to permanently wire two extension cords. One extension cord had a multi-plug adapter on it. Survey staff sent a follow-up email on July 28, 2022, at 7:47 a.m. to the LALD-A explaining that the extension cords and multi-plug adapter were being used improperly. The LALD-A confirmed receipt and responded that they would handle this on July 28, 2022, at 7:28 a.m. 2. Fire #1 was displayed on the fire alarm panel screen. The LALD-A explained that the fire alarm panel was not working and that the service company had already been contacted. During the facility tour, the fire alarm service provider arrived. At approximately 1:05 p.m., the LALD-A stated during an interview that the fire alarm panel had been repaired and was now operating correctly. The LALD-A showed survey staff the fire alarm panel and the screen displayed that the system was normal. 3. In a basement storage area, fire sprinkler heads were obstructed by boxes. The LALD-A confirmed during the facility tour that these boxes were stored too high and needed to be relocated. 4. One emergency light did not work in the hall. "Bad Light" was written on the testing record sticker punched with the year 2015. The LALD-A confirmed during the facility tour that the emergency light did not work. 5. The floor was starting to peel in the dining room near the patio door, creating a potential trip/fall hazard. 6. The bathtub was soiled in a common use resident bathroom. The LALD-A explained during the facility tour that all of the current residents used the walk-in shower instead of the bathtub. The LALD-A confirmed during the facility tour that	0 800		

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0 800	Continued From page 19 the dining room floor needed to be repaired and that the bathtub required cleaning. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, 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	0 810		

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0 810	Continued From page 20 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required employee training and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2022, at approximately 12:30 p.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on July 25, 2022, between 12:30 p.m. and 1:00 p.m. 1. The licensee failed to provide the required employee training frequency. The LALD-A explained during an interview, at approximately 12:55 p.m., that employee training for fire safety and evacuation was completed at the time of hire and then annually but did not require training at least twice per year after hire. An employee evacuation/fire safety training record was provided with a date of 03/16/22. 2. The licensee failed to provide the required evacuation drill frequency. A fire drill log was provided with a date of 06/13/22. The time or shift	0 810		

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0 810	Continued From page 21 of the drill was not recorded. At approximately 12:30 p.m., the LALD-A explained during an interview that evacuation drills were completed quarterly. Survey staff requested additional evacuation drill records. The LALD-A stated that they would call the main office to request this information. At approximately 12:50 p.m., the LALD-A returned and added 3/14/22 and 12/13/21 to the fire drill log. The time or shift of these drills was not included. The names of the employees who participated in these drills were not provided. On July 25, 2022, at approximately 1:10 p.m., the LALD-A confirmed during the exit interview that the licensee failed to provide the required frequency for employee training and evacuation drills. Survey staff discussed with the LALD-A that evacuation drills are required twice per year per shift with at least one evacuation drill every other month. It was also discussed that the records for all completed evacuation drills need to include both the date and shift. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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.	01620		

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01620	Continued From page 22 (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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments and did not exceed 90 days for one of two residents (R2) as required 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: R2	01620		

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01620	Continued From page 23 R2's Resident ADL's document dated July 2022 and treatment administration record (TAR) dated July 2022 indicated R2 received services including medication administration, dressing, TED assistance (compression stockings), assistive devices, grooming, transfer, peri-care, incontinence, safety checks every two hours, glucose (sugar) checks, daily housekeeping and bathing assist. On July 25, 2022, at approximately 11:55 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct R2's blood glucose (sugar) test with a result of 94 milligrams per deciliter (mg/dl). R2's record indicated the RN completed a remote Clinical Update Assessment on January 9, 2022, a Clinical Update Summary on April 11, 2022, and a Clinical Update Summary 90-day assessment on July 25, 2022. The July 25, 2022, 90-day assessment was completed in the afternoon on the day the survey began. R2's record lacked documentation the facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident after January 9, 2022. On July 27, 2022, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-F confirmed R2's ongoing reassessments were not completed at least every 90 days or prior to 90 days using the uniform assessment tool as required. Additionally, CNS-F stated "well, we could really use a nurse up there, so we're not spread so thin." The licensee's Initial and Ongoing Resident Evaluation and Assessments policy, undated, indicated an ongoing resident monitoring and reassessment would be conducted as needed based on changes in the needs of the resident and would not exceed 90 days from the last date	01620		

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CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 24 of assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for two of two residents (R1, 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 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 25 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: PRN EFFECTIVENESS R1 R1 was admitted for services on May 12, 2014, under the comprehensive license and began receiving services under the assisted living license August 1, 2021. R1's diagnoses included diabetes type II, hypertension and chronic obstructive pulmonary disease (COPD). R1's Service Plan dated May 16, 2022, indicated R1 received medication administration 11 times daily and PRN. R1's PRN Medication Record for July 2022, indicated: - on July 2, 2022, R1 received Ultram 50 milligram (mg) one tab every six hours for pain; - on July 3 and 22, 2022, R1 received two Ultram 50 mg tabs for pain; and - on July 4, 5, 7, 8, 10, 11, 12, 14, 15, 16, 17, 18, 21, 2022, R1 received one Ultram 50 mg tab for pain. R2 R2 was admitted for services on June 2, 2015, under the comprehensive license and began receiving services under the assisted living license August 1, 2021. R2's diagnoses included Parkinson's disease,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

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CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 26 hypothyroidism and diabetes. R2's service plan dated May 16, 2022, indicated R2 received medication administration nine times daily and PRN. R2's PRN Medication Record for July 2022, indicated: - on July 2, 11, 18, 2022, R2 received Milk of Magnesia 30 milliliters (mL) by mouth once daily; and - on July 15, 16, 17, 2022, R2 received Bacitracin/Neomycin/triple antibiotic ointment applied topically for a wound. R1 and R2's PRN medication record lacked documentation of the effectiveness of the PRNs given. On July 27, 2022, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-F stated the expectation for ULP's when administering as needed medications is they should follow the medication administration record (MAR) and document the effectiveness of the medication. Additionally, CNS-F stated "there is going to need to be some staff retraining with that. The paper system is not ideal." The licensee's Medication Management Services policy, undated, did not address PRN medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

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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
01940	Continued From page 27	01940		
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 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 observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for two of two residents (R1, R2) who	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(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
01940	Continued From page 28 received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included diabetes type II, hypertension and chronic obstructive pulmonary disease (COPD). R1's service plan dated May 16, 2022, indicated R1 received services including glucose (sugar) checks, compression stockings (TEDs), AFO braces (support for the ankle, keeping the toes aligned with the rest of the foot, rather than allowing them to drag) and nebulizer treatments. On July 26, 2022, at approximately 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct R1's blood glucose (sugar) test with a result of 87 milligrams per deciliter (mg/dl). R2 R2's diagnoses included Parkinson's disease, hypothyroidism and diabetes. R2's service plan dated May 16, 2022, indicated R2 received services including glucose (sugar) checks and assistance with R2's hand and neck brace.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

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CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(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
01940	Continued From page 29 On July 26, 2022, at approximately 11:55 a.m., the surveyor observed ULP-C conduct R2's blood glucose (sugar) test with a result of 94 milligrams per deciliter (mg/dl). R1 and R2's record lacked an Individualized Treatment and Therapy plan to include the following: - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On July 27, 2022, at approximately 10:00 a.m., administrator (A)-E confirmed R1 and R2 lacked Individualized Treatment and Therapy Plans to include above noted content. The licensee's Treatment and Therapy Policy, undated, did not address the requirement for an individualized treatment and therapy plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01950	Continued From page 30	01950		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure specific written instructions for each resident were documented in one of one resident record (R1) who received blood glucose monitoring. 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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

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01950	Continued From page 31 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included diabetes type II, hypertension and chronic obstructive pulmonary disease (COPD). R1's Service Plan dated May 16, 2022, indicated R1 received services including glucose (sugar) monitoring services. R1's July 2022, Treatment Administration Record (TAR) directed to check R1's fasting blood sugar daily. R1's record lacked specific written instructions to include parameters for monitoring R1's blood glucose results. On July 26, 2022, at approximately 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct R1's blood glucose (sugar) test with a result of 87 milligrams per deciliter (mg/dl). On July 27, 2022, at approximately 10:00 a.m., administrator (A)-E confirmed R1's record lacked specific written instructions to include parameters for blood glucose results. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	07/27/2022

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CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

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01960	Continued From page 32	01960		

assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of two residents (R1) 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:

R1
R1's diagnoses included diabetes type II, hypertension and chronic obstructive pulmonary disease (COPD).

R1's Service Plan dated May 16, 2022, indicated R1 received services ordered by R1's physician March 8, 2022, included TED stockings

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01960	Continued From page 33 (compression stockings to reduce edema) and assistance with ankle stretches before application of AFO braces (ankle supports to prevent foot drop). On July 26, 2022, at approximately 9:43 a.m., the surveyor observed unlicensed personnel (ULP)-D apply R1's TED stockings. R1's Treatment Administration Record (TAR) for July 2022 indicated R1's treatment record lacked documentation of completed treatments on the following dates and times: TED stocking application and removal records for July 2022 indicated staff had marked the service refused with a circle around staff's initials. Circling initials indicated the service had been refused, however, staff had not documented the reason for the refusal. Morning staff indicated with circled initials R1's refusal of the morning TED stocking application and the same dates morning staff indicated refusal, PM staff initialed the TED stockings had been removed. Discrepancies with documentation were indicated on the following dates below: a.m. application - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 2022. Staff had documented refusal of TEDs application. p.m. removal - staff had signed off that TEDs removal had been completed for each day noted above. Ankle stretches prior to application of AFO braces: a.m. - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 22, 23, 2022. On July 27, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-F confirmed	01960		

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01960	Continued From page 34 treatment documentation lacked for R1 on the above noted dates and times. Additionally, CNS-F stated that was "another item that would require staff retraining to be worked on." The licensee's Treatment and Therapy Management policy, undated, indicated documentation of treatments and therapies would be completed in the resident's treatment record and when treatments or therapies were not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *07/25/22*
Time: 11:42:00
Report: 1017221132

Food and Beverage Establishment Inspection Report

Location:
Central Minnesota Senior Care
1008 10th S S
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0039307
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188284823
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL SURFACE MEASURED 150 DEGREES F. UTENSILS WILL BE SANITIZED IN MAKE SHIFT SANITZER BUCKET AND DISPOSABLE UTENSILS (PLATES, FORKS, SPOONS) WILL BE USED IN INTERIM. HAVE DISH MACHINE SERVICED.

Comply By: 08/01/22

Surface and Equipment Sanitizers

Hot Water: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: LETTUCE UPRIGHT REFERIGERATOR
Violation Issued: No

Process/Item: Cooking
Temperature: 215 Degrees Fahrenheit - Location: GROUND BEEF LOCATED IN FRYING PAN
Violation Issued: No

Type: Full
Date: *07/25/22*
Time: 11:42:00
Report: 1017221132
Central Minnesota Senior Care

Food and Beverage Establishment Inspection Report

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

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 1017221132 of 07/25/22.

Certified Food Protection Manager: JENNIE LEE BIRD

Certification Number: FM 83790 Expires: 04/29/25

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: _____

Establishment Representative

INSPECTOR ID # 1017

651-201-4500
health.foodlodging@state.mn.us

Report #: 1017221132

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	07/25/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:42:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Central Minnesota Senior Care	**Address** 1008 10th S S	**City/State** Brainerd, MN	**Zip Code** 56401	**Telephone** 2188284823

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0039307		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 07/26/22

Inspector (Signature)