Electronically Delivered

February 1, 2024

Licensee
Autumn Lane, Inc.
36858 Pincherry Road
Cohasset, MN 55721

RE: Project Number(s) SL23725015

Dear Licensee:

On October 4, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 12, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 12, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 12, 2023, found not corrected at the time of the October 4, 2023, follow-up survey are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)
2040-Fire Protection And Physical Environment-144g.81 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on October 4, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

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

A state correction 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.

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	R 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LANE INC	36858 PINCHERRY ROAD COHASSET, MN 55721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL23725015-1 On October 4, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed between July 10, 2023, and July 12, 2023. At the time of the survey, there were nineteen (19) active resident receiving services under the Assisted Living Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.	{0 110}		

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{0 110}	Continued From page 1 This MN Requirement is not met as evidenced by: No further action needed.	{0 110}		
{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. (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: No further action needed.	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also	{0 550}		

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{0 550}	Continued From page 2 state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action needed.	{0 550}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action needed.	{0 630}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	{0 650}		

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{0 650}	Continued From page 3 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{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	{0 680}		

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{0 680}	Continued From page 4 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}		
{0 780} SS=E	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	{0 780}		

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{0 780}	Continued From page 5 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On October 4, 2023, between 10:30 a.m. and 11:10 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. The sleeping room smoke alarm in resident room 2 did not test as interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. 2. The smoke alarms in both basements did not test as interconnected with the other smoke alarms in the dwelling unit so that actuation of	{0 780}		

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{0 780}	Continued From page 6 one alarm would cause all alarms to operate. These deficient conditions were verified by the LALD-A accompanying on the facility tour.	{0 780}		
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include:	{0 800}		

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{0 800}	Continued From page 7 On October 4, 2023, between 10:30 a.m. and 11:10 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the fire sprinkler system tag was dated 2015. Documentation was not provided to support that an annual inspection had been completed on the fire sprinkler system. This deficient condition was verified by the LALD-A accompanying on the facility tour.	{0 800}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	{01060}		

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{01060}	Continued From page 8 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action needed.	{01060}		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: No further action needed.	{01460}		

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{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01750}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	{01910}		

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{01910}	Continued From page 10 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action needed.	{01910}		
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	{02040}		

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{02040}	Continued From page 11 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). Findings include: On October 4, 2023, between 11:10 a.m. and 11:45 a.m., a record review and interview were completed. Record review of the available documentation indicated that the licensee had not finished the safety risk assessment of the physical environment with mitigation factors. An assessment of the physical environment that identified safety risks or hazards on and around the property with mitigation factors had not been completed. On October 4, 2023, at approximately 11:45 a.m., the licensed assisted living director (LALD)-A verified this deficient condition.	{02040}		
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action needed.	{02310}		
{02410} SS=F	144G.91 Subd. 13 Personal and treatment privacy	{02410}		

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{02410}	Continued From page 12 (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 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 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: No further action needed.	{02410}		

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

Type: Full
Date: *08/10/23*
Time: 14:11:22
Report: 7939231137

Food and Beverage Establishment Inspection Report

Location:
Autumn Lane Inc
36858 Pincherry Road
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0039278
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183280225
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.

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

FOLLOW-UP INSPECTION ALL ORDERS COMPLIED WITH.

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 7939231137 of 08/10/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed: NA

LEANNE
OWNER

Signed: _____

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

Electronically Delivered

July 25, 2023

Licensee
Autumn Lane Inc.
36858 Pincherry Road
Cohasset, MN 55721

RE: Project Number(s) SL23725015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LANE INC	36858 PINCHERRY ROAD COHASSET, MN 55721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23725015-0 On July 10, 2023, through July 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 20 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 10, 2023, at 10:15 a.m., LALD-D identified himself as the current LALD for the facility. On July 10, 2023, at 7:21 p.m., the evaluator reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website. The BELTSS website indicated LALD-A held a current assisted living director licenses issued January 11, 2022; and would expire October 31, 2023. The BELTSS website did not indicate LALD-A as the Director of Record. On July 12, 2023, at 12:33 p.m., LALD-A stated he thought he was listed as the Director of Record for the facility and must not have	0 110		

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0 110	Continued From page 2 completed the process. LALD-A provided the surveyor with a copy of the updated BELTSS website listing LALD-A as the Director of Record for the licensee effective July 12, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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	0 480		

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0 480	Continued From page 3 dated July 10, 2023, 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. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed for hand hygiene and disinfecting reusable equipment for three of three unlicensed personnel (ULP)-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 510		

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: On July 11, 2023, at 6:52 a.m., the surveyor observed ULP-F obtain R12's blood sugar check of 76. After performing R12's blood sugar, ULP-F removed gloves, and returned the blood glucose meter and injector back into the basket on the table next to the medication cart without disinfecting the machine. ULP-F did not perform hand hygiene after the removal of gloves and proceeded to escort R13 back to her room and assist with putting on R13's shirt then washed hands at sink. On July 11, 2023, at 7:42 a.m., the surveyor observed ULP-E check R7's blood pressure. After completing R7's blood pressure, ULP-E put the blood pressure machine in her pocket, assisted R7 to the breakfast table and returned the blood pressure cuff in the bag hanging on the medication storage room door without disinfecting the equipment. On July 11, 2023, at 7:48 a.m., ULP-F stated he had not been trained on disinfecting the shared blood glucose meter after resident use. ULP-F stated he would probably clean the blood glucose machine with alcohol prep pads. On July 11, 2023, at 9:08 a.m., the surveyor observed ULP-G obtain R8's blood glucose check of 128, then returned the injector and the blood glucose meter back into the basket without disinfecting equipment. On July 11, 2023, at 2:47 p.m., clinical nurse supervisor (CNS)-C stated staff should be disinfecting share equipment after each use with	0 510		

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0 510	Continued From page 5 alcohol prep pads. CNS-C stated she was unsure what the manufacturer instructions were to clean the shared Accu Check Guide meter. Registered nurse (RN)-D stated hand hygiene was to be completed before entering and after exiting a resident's room, after the removal of gloves and in between resident cares. The manufacturer instructions for Accu Check Guide meter dated 2023, directed to disinfect the meter and lancing device with Super-Sani Cloth disposable wipes. The licensee's Cleaning of Shared Medical Equipment Policy and Procedure dated August 1, 2021, indicated the licensee would follow current infection control practices to prevent or reduce the risk of communicable or infectious disease transmission within the facility among residents, employees, and visitors by ensuring processes are in place for cleaning and disinfecting shared medical equipment. Shared medical equipment includes, but is not limited to: -stethoscopes; -blood pressure cuffs; -machines oximeters; -thermometers; and -mechanical lifts. The licensee's Blood Sugar Testing-Shared equipment Use policy dated August 1, 2021, indicated to clean and disinfect the glucometer per manufacture's recommendations and consistent with the Center for Disease Control (CDC) guidelines. The licensee's Hand Hygiene policy dated December 1, 2021, indicated hand hygiene would be completed:	0 510		

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0 510	Continued From page 6 -before and after the provisions of any care to a resident; and -during glove changes when gloves become soiled or moving from a dirty to a clean area during the provision of care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors.	0 550		

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0 550	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on July 10, 2023, at 10:59 a.m., the surveyor observed and confirmed, with program coordinator/owner (PC/O-B), the licensee's grievance procedure was not posted with the required content to indicate the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 8 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include all the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (lung disease that causes shortness of breath), hypertension (high blood pressure), and congested heart failure. R3's Service Plan dated July 10, 2023, indicated R3's services included dressing, grooming, bathing, medication management, wound care, housekeeping and laundry. On July 11, 2023, at 8:12 p.m., the surveyor observed licensed assisted living director (LALD)-A administering R3's eye drops and inhaler. R3's comprehensive assessment dated July 11, 2023, identified areas of vulnerabilities with	0 630		

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0 630	Continued From page 9 interventions; however, lacked a review of R3's risk of self-abuse and the risk to abuse other vulnerable adults. On July 12, 2023, at 10:30 a.m., registered nurse (RN)-D stated the licensee's comprehensive assessment included the required IAPP questions. RN-D reviewed R3's comprehensive assessment dated July 10, 2023, and stated R3's assessment did not include risk of self-abuse or risk to abuse other vulnerable adults. The licensee's Individual Abuse Prevention Plan dated August 1, 2021, the licensee would develop and implement an IAPP for each vulnerable adult. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: -other vulnerable adults; -the person's risk of abusing other vulnerable adult; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650		

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0 650	Continued From page 10 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-E, registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 650		

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0 650	Continued From page 11 ULP-E ULP-E had a start date of November 16, 2015, to provide direct care under the licensee's assisted living license. On July 11, 2023, at 7:42 a.m., the surveyor observed ULP-E monitor R7's blood pressure. On July 11, 2023, at 8:27 a.m., the surveyor observed ULP-E change R9's Freestyle Libre sensor (continuous blood glucose monitoring device). ULP-E stated R9's Libre sensor was changed every 14 days by the ULPs and was trained by RN-C. ULP-E's employee record lacked documentation of the following training and competency (*indicates competency required) evaluations: -documentation requirements for all services provided; -*care and use of hearing aids; -*standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of commonly used health technology equipment and assistive devices; -observation, reporting, and documenting of client status; -*reading and recording temperature, pulse, and respirations of the residentt; -*range of motioning and positioning; and	0 650		

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0 650	Continued From page 12 -*other RN/professionally delegated tasks (i.e., monitoring vital signs, Broda chair, Libre device). On July 12, 2023, at 10:44 a.m., program coordinator/owner (PC/O)-B stated she was unsure why ULP-E's employee record lacked evidence ULP-E completed all the required training and evaluations noted above. PC/O-B stated there had been a few turnovers with the RNs and there has not been consistency in how staff training were being completed and documented. RN RN-D was had a start date of June 3, 2023, to supervise and provide direct care services to the licensee's residents. During July 11, 2023, through July 12, 2023, the surveyor observed RN-D provide services to the licensee's residents. RN-D's employee record lacked evidence RN-D completed tuberculoses (TB) training. On July 11, 2023, at 3:53 p.m., clinical nurse supervisor (CNS)-C stated ULPs were trained on both the Dexcom and Libre devices; however, did not have documentation staff were trained and competency evaluations were completed. CNS-C provided the surveyor with RN-D's employee record and stated RN-D had not completed all the required orientation training including TB training. On July 12, 2023, at 12:58 p.m., RN-D stated she had not completed TB training and was in the process of completing the required training through Educare (online training courses). The licensee's Training Records policy dated	0 650		

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0 650	Continued From page 13 August 1, 2021, indicated the licensee would document the following information for each competency evaluation, training, retraining, and orientation topic. The licensee's Employee Records policy dated August 1, 2021, indicated employee records would be kept up-to-date and include: -records of all training and in-service education required and/or provided including record of competency testing as required; and -verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 14 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 develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated September 2022, did not include the development of following policies and procedures to include: - a quarterly review of the missing resident policy; - a description of population served by the licensee; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, and emergency lighting); - evacuation plan which included transporting services for residents being evacuated;	0 680		

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0 680	Continued From page 15 - development of arrangements with other facilities and providers to receive residents if needed; - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; and - a communication plan that included: - names and contact information for entities providing services under arrangement, resident physicians, other facilities, volunteers; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; - alternate ways of communication; and - a method of sharing information from the EPP with residents and their families; and - an emergency prep training program. On July 12, 2023, at 2:46 p.m., licensed assisted living director (LALD)-A stated he had not fully developed the licensee's EPP. The surveyor and LALD-A reviewed the licensee's EPP and LALD-A confirmed the EPP was missing the required content noted above. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 16 (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 to provide smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	0 780		

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0 780	Continued From page 17 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). Findings include: On July 11, 2023, between 10:15 a.m. and 12:15 p.m., survey staff toured the facility with the program coordinator/owner (PC/O)-B, registered nurse (RN)-D, and the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. The sleeping room smoke alarm in resident room 13 did not test as interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. 2. The smoke alarm was missing from the bracket on the ceiling outside the bedroom in resident room 13. 3. Both basements had smoke detectors equipped with audible speaker bases as part of the central fire alarm system. Interconnected smoke alarms were not installed on each story within the dwelling unit, including basements. These deficient conditions were verified by the LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 18 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On July 11, 2023, between 10:15 a.m. and 12:15 p.m., survey staff toured the facility with the program coordinator/owner (PC/O)-B, registered nurse (RN)-D, and the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed portable fire extinguishers stored on the floor. Fire extinguishers must be properly mounted to prevent them from being moved or damaged.	0 790		

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0 790	Continued From page 19 This deficient condition was verified by the PC/O-B and LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 800		

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0 800	Continued From page 20 Findings include: On July 11, 2023, between 10:15 a.m. and 12:15 p.m., survey staff toured the facility with the program coordinator/owner (PC/O)-B, registered nurse (RN)-D, and the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. Annual inspections were not being completed on the fire sprinkler system. The inspection tag on the fire sprinkler system was dated 2015. 2. Smoke alarms did not provide an audible warning when tested by the LALD-A in these locations: a. In the hallway outside resident room 13 b. In resident sleeping room 14 c. In the living room, outside resident room 14 d. In the dayroom, outside the sleeping areas for resident rooms 1 and 2 3. The lock was not working on the door for the chemical closet located in the hallway. 4. The door leading to the deck had an exit sign posted over it and a key-only lock was installed on the gate. The LALD-A explained during the tour that two keys were available for this lock. All paths of egress must be maintained to allow occupants to exit the building in a safe and efficient manner in the event of an emergency 5. Three septic tank covers were unsecured. All the screws were missing from one septic tank cover. The covers for two additional septic tanks were loose with only one screw installed on each cover. 6. An exterior light fixture was hanging loose with capped electrical wires exposed above the deck for resident room 13, presenting an electrical hazard. These deficient conditions were verified by	0 800		

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0 800	Continued From page 21 PC/O-B, RN-D, and LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 22 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to document the required training for employees on the fire safety and evacuation plans; and failed to meet the evacuation drill frequency requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 11, 2023, at approximately 12:20 p.m., records were provided for review. Records were reviewed by survey staff on July 11, 2023, between 12:20 p.m. and 1:10 p.m. Record review of available documentation indicated that the licensee had not developed fire safety and evacuation plans with procedures that included the identification of unique or unusual resident needs for movement or evacuation. Additionally, the 7.05 Fire Policy references smoke compartments, but these areas are not identified in the plans.	0 810		

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0 810	Continued From page 23 Record review of the available documentation did not support that the employee training on the fire safety and evacuation plans had been completed upon hire and at least twice per year thereafter. One employee training session dated 10-06-2021 was provided for review. Record review of documented evacuation drills indicated that evacuation drills for employees had been completed on 03-18-2023 and 06-13-2023. No additional evacuation drill records were provided. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On July 11, 2023, at approximately 1:20 p.m., the licensed assisted living director (LALD)-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820		

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0 820	Continued From page 24 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. 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 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). Findings include: On July 11, 2023, between 10:15 a.m. and 12:15 p.m., survey staff toured the facility with the program coordinator/owner (PC/O)-B, registered nurse (RN)-D, and the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. Chain locks were installed near the top of two marked exit doors and on two additional doors that were designated as exits on the fire safety and evacuation plans. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. 2. Space heaters were observed in dementia care resident rooms. Additional space heaters were observed in common-use areas of the facility.	0 820		

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0 820	Continued From page 25 These deficient conditions were verified by PC/O-B, RN-D, and LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 26 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (lung disease that causes shortness of breath), (hypertension (high blood pressure), and congested heart failure. R3's Service Plan dated July 10, 2023, indicated	01060		

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01060	Continued From page 27 R3's services included dressing, grooming, bathing, medication management, wound care, housekeeping and laundry. R3's progress notes dated June 26, 2023, indicated R3 had a hospital stay from June 22 through June 26, 2023, for treatment of pneumonia and congested obstructive pulmonary disease exacerbation (flare up). R3's record lacked documentation R3 and/or R3's legal representative, or designated representative received an emergency relocation notice. On July 12, 2024, program coordinator/owner (PC/O)-B stated she was unaware an emergency relocation notice needed to be provided to the resident and/or resident's representative and was also unaware the Ombudsman needed to be notified when a resident was in the hospital more than four (4) days. The licensee's Emergency Relocation policy dated August 1, 2021, in the event of an emergency relocation the licensee would provide a written notice that contains at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known as applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal; and -the licensee would deliver a written notice to the	01060		

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01060	Continued From page 28 resident, their legal representative, and their designated representative as soon as possible. A written notice should be delivered to the Office of Ombudsman for Long Term Care as soon as possible and within 24 hours if the resident has relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was completed for one of two employees (registered nurse (RN)-D). This has the potential to affect all 20 residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01460		

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01460	Continued From page 29 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: RN-D was hired June 3, 2023, to provide direct care services to the licensee's residents. RN-D's employee record lacked orientation to assisted living requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01460		

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01460	Continued From page 30 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On July 11, 2023, through July 12, 2023, the surveyor observed RN-D provide services to the licensee's residents. On July 12, 2023, at 12:58 p.m., RN-D stated she had not completed the required training noted above before providing services to licensee's residents and was currently in the process of completing the training through Educare (online training courses). The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated all staff of the licensee providing and supervising direct services must complete an orientation to Assisted Living facility requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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01750	Continued From page 31 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure specific instructions were in the resident record related to administering medications according to manufacturer's instructions for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (lung disease that causes shortness of breath), hypertension (high blood pressure), and congested heart failure. R3's Service Plan dated July 10, 2023, indicated R3 received medication management. R3's prescriber orders dated June 21, 2022, included Advair HFA 45-21 micrograms (mcg)	01750		

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01750	Continued From page 32 inhale two (2) puffs into the lungs twice a day. R3's July 2023, medication administration record (MAR) indicated R3 received Advair HFA 45-21 mcg inhale two (2) puffs twice daily. R3's MAR lacked specific written instructions for the use of the inhaler to include: to shake the inhaler, instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs. Wait at least one (1) minute in between puffs of same medication. On July 11, 2023, at 8:12 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R3's Advair inhaler. LALD-A shook the inhaler, handed the inhaler to R3, and instructed R3 to take two puffs of the inhaler. R3 took a breath in while administering one puff of the inhaler, released her breath, then immediately administered the second puff of the inhaler. LALD-A handed the resident a cup of water and instructed R3 to rinse her mouth out and spit into the empty cup. LALD-A documented in R3's MAR inhaler administered. LALD-A stated R3's electronic record did not include written instructions on inhaler administration. On July 10, 2023, at 2:47 p.m., clinical nurse supervisor (CNS)-C stated R3 was assessed and able to self-administer her inhaler after set-up. CNS-C stated staff should be observing and instructing R3 on the steps for proper administration. On July 11, 2023, at 10:30 a.m., registerd nurse (RN)-D reviewed R3's MAR and electronic records and stated there were no written instructions on the use of the inhaler and should	01750		

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01750	Continued From page 33 be included on R3's MAR. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated when medication management is delegated to an unlicensed personnel (ULP), the RN would, specify, in writing, specific instructions for each resident and document those instructions in the resident records. The licensee's Inhaler policy dated August 1, 2021, indicated to remove cap from mouthpiece, shake the inhaler for 5-10 seconds, position inhaler upside down with mouthpiece on the bottom. Place the resident in an upright position and tilt the head back slightly and breathe out. Instruct the resident to the number of puffs ordered and to close their mouth around the mouthpiece. Instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs. Wait at least one (1) minute in between puffs of same medication. Provide resident the opportunity to rinse out mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910		

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01910	Continued From page 34 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R1) upon discharge. 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 was discharged on April 2, 2023. R1's undated Discharge-Transfer Summary,	01910		

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01910	Continued From page 35 indicated R1 received assistance with medication administration and storage. R1's February 2023, Medication Administration Record (MAR), indicated R1 received the following medications: -fish oil 1000 milligrams (mg) one soft gel daily; -focal point one capsule daily; -Loperamide two (2) mg one capsule in the morning; -acetaminophen 500 mg two (2) tablets three times a day; -acetaminophen one suppository three (3) times a day as needed for pain or fever; -glucosamine hcl and chondroitin 1500/1200 mg two (2) tablets daily; -vitamin D 125 micrograms (mcg) one capsule daily; -mirtazapine 7.5 mg one tablet every evening; -Omeprazole 20 mg one capsule daily; -Epicore high metabolic immogens 500 mg one; and -dilaudid 8 mg 1.5 mg tablets every hour as needed for pain or shortness of breath. R1's Narcotic's Log indicated on March 1, 2023, at 4:40 a.m., R1 had 43.5 tablets of hydromorphone (Dilaudid) 8 mg tablets remaining. R1's Medication Disposition recorded dated March 1-July 10, 2023, lacked prescriptions numbers for prescribed medications provided by the pharmacy, and did not include the list of medications noted above. On July 10, 2023, at 2:29 p.m., clinical nurse supervisor (CNS)-C stated the prescription numbers listed on the medication disposition record auto populated if the medications were	01910		

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01910	Continued From page 36 provided by the primary pharmacy the licensee used. CNS-C stated the medications listed on R1's Medication Disposition record that did not include the prescription numbers were medications provided by hospice and she did not include those prescription numbers on the medication disposition sheets. CNS-C stated she returned all of R1's over the counter medications to R1's family and did not list the over-the-counter medications on R1's Medication Disposition record or document in R1's record. On July 10, 2023, at 3:10 p.m., CNS-C and program coordinator/owner (PC/O)-B reviewed R1's Narcotic Record and stated R1 had 43.5 tablets of Dilaudid 8 mg remaining and should have been listed on R1's Medication Disposition record. PC/O-B stated herself and CNS-C destroyed R1's medications together including R1's Dilaudid 8 mg tablets and did not know why the Dilaudid 8 mg tablets were not listed on R1's Medication Disposition and planned to investigate further. The licensee's Resident Discharge Summary form dated June 2021, indicted the discharge summary would include a reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over the counter medications. The licensee's Medication Disposal policy dated August 1, 2021, indicted the licensee would document any unused prescription drugs in the resident record to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. Any unused controlled substances, the licensee must	01910		

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01910	Continued From page 37 document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 38 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 11, 2023, at approximately 12:20 p.m., records were provided for review. Records were reviewed by survey staff on July 11, 2023, between 12:20 p.m. and 1:10 p.m. Record review of the available documentation indicated that the licensee had included a Hazard and Vulnerability Assessment Tool that identified natural, technological, and human hazards. An assessment of the physical environment that identified safety risks or hazards on and around the property with mitigation factors had not been completed. On July 11, 2023, at approximately 1:20 p.m., the licensed assisted living director (LALD)-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with regards to safety of oxygen storage for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (lung disease that causes shortness of breath), and congested heart failure. R3's Service Plan dated July 10, 2023, indicated R3's services included oxygen management. On July 10, 2023, at 10:59 a.m., during the facility tour with program coordinator/owner (PC/O)-B, the surveyor observed an oxygen concentrator in R3's room, no oxygen signage posted and three (3) unsecured oxygen cylinders being stored directly on R3's floor. PC/O-B stated she was present when the oxygen supply company delivered R3's oxygen and was unaware the oxygen cylinders were not stored in a secured holder.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LANE INC	36858 PINCHERRY ROAD COHASSET, MN 55721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 40 The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=F	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 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 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	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	07/12/2023

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02410	Continued From page 41 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, interview and record review, the licensee failed to ensure three of three residents (R6, R3, R8) were treated with dignity and respect when provided treatment and medication management services in a public setting. In addition, the licensee failed to ensure privacy was maintained for and one of three residents (R5) during person cares. 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: MEDICATIONS AND TREATMENTS R6 R6's diagnoses included dementia and dry eyes. R6's Service Plan dated June 26, 2023, indicated R6 received medication administration. On July 11, 2023, at 7:16 a.m., during breakfast, the surveyor observed licensed assisted living director (LALD)-A administer R6's Xiidra eye drops at the dining table with other residents	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	07/12/2023

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02410	Continued From page 42 present. R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (lung disease that causes shortness of breath). R3's Service Plan dated July 10, 2023, indicated R3's services included medication administration. On July 11, 2023, at 8:12 a.m., during breakfast, the surveyor observed LALD-A administer R3's olopatadine eye drops and Advair inhaler at the dining room table with other residents present. R8 R8's diagnosis included type two diabetes and dementia. R8's Service Plan dated May 13, 2022, indicated R8 received blood glucose monitoring. On July 11, 2023, at 9:08 a.m., the surveyor observed unlicensed personnel (ULP)-G conduct R8's blood glucose check at the dining room table with other residents present. On July 11, 2023, at 9:38 a.m., ULP-G stated staff were able to administer eye drops, inhalers, and check blood glucose in a public setting. R6, R3, and R8 were not offered to recieve medications or treatments in a private area, nor were they asked permission to complete the tasks in a public setting. PRIVACY R5's diagnosis included Alzheimer's disease. R5's Service Plan dated September 29, 2022,	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23725	A. BUILDING: _____ B. WING _____	07/12/2023

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02410	Continued From page 43 indicated R5 received services to including assistance with bathing, dressing, grooming, transferring, and toileting. On July 11, 2023, at 7:00 a.m., the surveyor observed ULP-E, ULP-G, and ULP-H assist R5 with transferring and morning cares. ULP-H washed and dried R5's bottom area while R5's backside was exposed to the open window overlooking the large outside deck. After R5's incontinent cares were completed, R5's pants were pulled up, transferred into the wheelchair, and escorted to breakfast. At 7:07 a.m., ULP-E stated normally she makes sure the curtains were closed when providing resident cares and did not realize the curtain was opened during R5's cares. On July 11, 2023, at 2:47 p.m., clinical nurse supervisor (CNS)-C stated it was important to make sure privacy was provided for residents during resident cares. CNS-C stated staff were allowed to administer eye drops, inhalers, and check blood glucose in a public setting. CNS-C stated she had not considered it being a privacy or dignity concern for the residents. The licensee's Eye Drops and Eye Ointment policy, Inhaler policy and Blood Sugar Testing-Shared Equipment Use policy dated August 1, 2021, indicated when administering eye and inhaler medications and blood glucose monitoring to provide privacy for the individual. The licensee's undated Minnesota Assisted Living Bill of Rights indicated a person who resides in an assisted living community has the right to be treated with courtesy and respect. No further information was provided.	02410		

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02410	Continued From page 44 TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *07/10/23*
Time: 11:20:20
Report: 7939231110

Food and Beverage Establishment Inspection Report

Location:
Autumn Lane Inc
36858 Pincherry Road
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0039278
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183280225
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

4-703.11A ***** Priority 1 *****

MN Rule 4626.0905A Sanitize food contact surfaces of equipment and utensils after cleaning by immersion for at least 30 seconds in hot water maintained as specified in rule.

WARE WASH MACHINE WAS NOT REACHING 160F TEMPERATURE TO SANITIZE DISHES

Comply By: 07/10/23

5-100 Water

5-101.11P ***** Priority 1 *****

MN Rule 4626.0980 Provide well caps which are in good condition and firmly attached to the well casing.

WELL CAP WAS NOT SECURE AND WAS EASILY REMOVED

Comply By: 07/10/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

WARE WASH MACHINE NOT REACHING PROPER TEMPERATURE TO SANITIZE DISHES

Comply By: 07/10/23

Surface and Equipment Sanitizers

Hot Water: = at <160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: CHICKEN BASE
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: OJ
Temperature: 38 Degrees Fahrenheit - Location: PANTRY FRIDGE
Violation Issued: No

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

ESTABLISHMENT HAS A THREE COMPARTMENT SINK TO USE UNTIL THE WARE WASH MACHINE CAN BE FIXED

SINK 1 - SOAPY WATER
SINK 2 - CLEAN RINSE WATER
SINK 3 - SANITIZER, DISCUSSED 1/2 CAP OF BLEACH
AIR DRY DISHES AND ONLY CHANGE WATER WHEN IT BECOMES SOILED

A FOLLOW UP INSPECTION WILL OCCUR WHEN THE DISH MACHINE IS FIXED.

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 7939231110 of 07/10/23.

Certified Food Protection Manager: DAVED BRENDEN

Certification Number: FM24714 Expires: 11/14/25

Signed: _____
DAVID BRENDEN
COOK

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