DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 19, 2022

Administrator
The Legacy
622 East 7th Street
Morris, MN 56267

RE: Project Number(s) SL32429015

Dear Administrator:

On November 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 12, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

Electronically Delivered

October 19, 2022

Administrator
The Legacy
622 East 7th Street
Morris, MN 56267

RE: Project Number(s) SL32429015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 12, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

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

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

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

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32429	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY	622 EAST 7TH STREET MORRIS, MN 56267

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#32429015 On, October 10, 2022, through October 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 30 residents, all of whom received services under the provider's Assisted Living with Dementia license. An immediate correction order was identified on October 11, 2022, issued for SL#32429015, tag identification 2310. On October 11, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of H.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 dated October 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 490	Continued From page 2	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 30 residents who were being provided services at the facility. This practice resulted in a level two violation (a	0 490		

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0 490	Continued From page 3 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 October 10, 2022, at 1:52 p.m., the surveyor toured the facility with registered nurse (RN)-C and licensed assisted living director (LALD)-A. The October 2022, activity calendar was posted on a large white board in the common area outside of the main dining room and on the nurses' station counter in the memory care unit. The calendar included at least one daily scheduled activity except for Sunday October 2, 9, 16, 23, and 30th. The date boxes for these dates were left blank. On October 10, 2022, at 2:10 p.m., the surveyor asked for the licensee's daily activity calendar for September and October. The September and October activity calendars were provided and reviewed with LALD-A. The October activity calendar was the same as what was posted. The September 2022 activity calendar was noted to include at least one scheduled daily activity except for Sunday 4, 18, and 25th. LALD-A stated they do not routinely have an activity scheduled or planned for Sundays. LALD-A stated the staff will sometimes do impromptu activities, but nothing was routinely scheduled. The licensee's ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated July 2, 2021, noted a monthly activity calendar is developed and a copy	0 490		

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0 490	Continued From page 4 is given to each resident. A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in the memory care unit to include posting the 911 emergency number in common area and near telephones provided by the assisted living. This had the potential to affect all 5 residents of residing in the memory care unit, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 640		

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0 640	Continued From page 5 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 11, 2022, at approximately 6:35 a.m., the surveyor did not observe 911 posted on or near telephones (one land line phone, one cordless phone) positioned on a desk in the common's area of the memory unit. On October 11, 2022, at 7:31 a.m., licensed assisted living director (LALD)-A verified the 911 emergency number was not posted near or on the phones in the memory care unit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	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, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650		

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0 650	Continued From page 6 (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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee, unlicensed personnel (ULP)-E. 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: ULP-E was hired on November 22, 2021, to	0 650		

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0 650	Continued From page 7 provide direct care services to residents of the facility. On October 11, 2022, at 7:34 a.m., the surveyor observed ULP-E enter R2's room and hold a Freestyle Libre2 meter (system to monitor glucose [sugar] levels with a painless one second scan) up to a sensor attached to R2's upper arm to get a blood glucose reading. ULP-E's employee file lacked evidence of training and competency of the Freestyle Libre 2 system. On October 12, 2022, at 9:32 a.m., RN-C stated ULP-E was trained verbally of how to use the Libre system. RN-C verified there was no documentation of this training in ULP-E's file. RN-C verified there was no documentation of training on the Libre system in any of the ULPs files. The licensee's Orientation & Training policy revised July 8, 2021, indicated the facility would maintain a record of staff training and competency to include: -name of the training topic or training program; -the training methodology, such as classroom style, web-based training, video, or one-to-one training; -date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation; -name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluators' s signature with a statement attesting that the employee successfully completed the training and competency evaluation; -name and title of the staff person completing the	0 650		

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0 650	Continued From page 8 training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation; and -documentation of the completed competency evaluation, training, retraining, or orientation would be provided to the employee at the time the evaluation or training is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 650		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) prior to providing care, for one of one ULP (ULP-E).	01360		

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01360	Continued From page 9 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: ULP-E was hired on November 22, 2021, to provide direct care services to residents of the facility. On October 11, 2022, at 7:34 a.m., the surveyor observed ULP-E enter R2's room and hold a Freestyle Libre2 meter (system to monitor glucose [sugar] levels with a painless one second scan) up to a sensor attached to R2's upper arm to get a blood glucose reading. On October 12, 2022, at 10:58 a.m., RN-C stated ULPs are hired, and start with EduCare (an online training program). RN-C added in "a perfect world" all the EduCare assigned topics would be completed before the ULPs were on the floor. New ULPs are then scheduled to work on the floor [unit] with another staff (ULP) "for a while". RN-C explained, as an example, if the ULP was hired for the evening shift the newly hired ULP would work with another ULP for two day shifts, and then work three afternoon shifts with another ULP before they worked on their own. However, prior to new ULPs being on their own, an RN does competency testing/skills check off with the new ULP. RN-C stated her expectations are that new ULPs perform tasks such as medication administration and blood glucose testing with the	01360		

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01360	Continued From page 10 ULP they are assigned to work with prior to competency testing with the RN. RN-C added, "we want them [ULP] doing them [skills/tasks]." RN-C verified all ULP's are hired and trained this way and indicated their process would need to be changed. On October 12, 2022, at 11:10 a.m., ULP-E stated she was hired, did some computer work, then worked with [named ULP] and then worked with another ULP in the memory unit. "The first day, I just watched and the second day they (ULP) watched me." ULP-E added later an RN went over things with me, "to make sure I was doing them right." The licensee's Orientation & Training policy revised July 8, 2021, indicated all of the staff at the facility providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 11 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed in all required areas for one of one unlicensed personnel (ULP)-E to include all required content.	01370		

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01370	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 22, 2021, to provide direct care services to residents of the facility. On October 11, 2022, at 7:34 a.m., the surveyor observed ULP-E enter R2's room and hold a Freestyle Libre2 meter (system to monitor glucose [sugar] levels with a painless one second scan) up to a sensor attached to R2's upper arm to get a blood glucose reading. ULP-E's employee record lacked evidence to indicate ULP-E completed the following training: - basic nutrition, meal preparation, food safety, and assistance with eating: and - preparation of modified diets as ordered by a licensed health professional. On October 12, 2022, at 11:48 a.m., registered nurse (RN)-F confirmed ULP-E had not completed the required training noted above. RN-F commented the above classes have been now assigned to ULP-E. The licensee's Competency Training Evaluations policy revised July 8, 2021, indicated training and competency evaluations for all ULPs would include:	01370		

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01370	Continued From page 13 -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 14 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees, unlicensed personnel (ULP)-E. 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	01470		

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01470	Continued From page 15 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 22, 2021, to provide direct care services to residents of the facility. On October 11, 2022, at 7:34 a.m., the surveyor observed ULP-E enter R2's room and hold a Freestyle Libre2 meter (system to monitor glucose [sugar] levels with a painless one second scan) up to a sensor attached to R2's upper arm to get a blood glucose reading. ULP-E's employee record did not include documentation of training for the following topics: - an overview of the 144 G statutes; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. On October 12, 2022, at 11:48 a.m., registered nurse (RN)-F verified ULP-E had not completed the above noted orientation as required, "it got missed somehow, but I have added it for her." The licensee's orientation & Training policy revised July 8, 2021, indicated all staff of the facility providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents, to include:	01470		

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01470	Continued From page 16 - an overview of the 144 G statutes; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel/ULP-D) observed administering medications.	01760		

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01760	Continued From page 17 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: R10's diagnoses included atrial fibrillation (irregular often fast heart rate), hypertension (HTN-high blood pressure), and congested heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should). R10's service plan dated June 1, 2022, indicated the resident received services which included medication administration twice daily. On October 11, 2022, at 7:17 a.m., the surveyor observed ULP-D conduct a medication pass for R10 and the following was observed: - ULP-D entered R10's room and removed from the locked cupboard R10's weekly preset medication planner (a plastic medication box with designated compartments for days and times) - ULP-D removed five pills from the morning compartment of the medication planner and placed the pills into a medication cup - ULP-D handed the medication cup to R10 and completed the medication pass ULP-D exited the room and proceeded to conduct a medication pass for R11. ULP-D did not check R10's electronic medication administration record (MAR) directly prior to administering R10's scheduled morning medications. Nor did ULP-D	01760		

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01760	Continued From page 18	01760		

document on R10's MAR that the medications had been administered directly following the above noted medication pass.

R11
R11's diagnoses included HTN, hyperlipidemia (high cholesterol), and gastroesophageal reflux disease (GERD-acid reflux).

R11's service plan dated May 31, 2022, indicated the resident received services which included medication administration four times daily.

On October 11, 2022, at 7:20 a.m., the surveyor observed ULP-D conduct a medication pass for R11 and the following was observed:
- ULP-D entered R11's room and removed from the locked cupboard R11's weekly preset medication planner
- ULP-D removed three pills from the morning compartment of the medication planner and placed the pills into a medication cup
- ULP-D handed the medication cup to R11 and completed the medication pass

ULP-D exited the room and proceeded to conduct a medication pass for R4. ULP-D did not check R11's electronic MAR directly prior to administering R11's scheduled morning medications. Nor did ULP-D document on R11's MAR that the medications had been administered directly following the above noted medication pass.

R4
R4's diagnoses included dementia, anemia (condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues), obstructive sleep apnea (intermittent airflow blockage during sleep), HTN and CHF.

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01760	Continued From page 19 R4's service plan dated June 5, 2022, indicated the resident received services which included daily medication administration. On October 11, 2022, at 7:33 a.m., the surveyor observed ULP-D conduct a medication pass for R4 and the following was observed: - ULP-D entered R4's room and removed from the locked cupboard R4's weekly preset medication planner - ULP-D removed one pill from the morning compartment of the medication planner and placed the pill into a medication cup - ULP-D handed the medication cup to R4 and completed the medication pass ULP-D exited the room and proceeded to conduct a medication pass for R5. ULP-D did not check R4's electronic MAR directly prior to administering R4's scheduled morning medication. Nor did ULP-D document on R4's MAR that the medication had been administered directly following the above noted medication pass. R5 R5's diagnoses included diabetes, CHF, HTN, anxiety and atrial fibrillation. R5's service plan dated May 31, 2022, indicated the resident received services which included medication administration six times daily. On October 11, 2022, at 7:35 a.m., the surveyor observed ULP-D conduct a medication pass for R5 and the following was observed: - ULP-D entered R5's room and removed from the locked cupboard a bottle of refresh eye drop solution (medication to treat dry eyes) - using appropriate technique ULP-D	01760		

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01760	Continued From page 20 administered one drop into each eye ULP-D exited R5's room and was on her way to complete another resident's medication pass. ULP-D did not check R5's electronic MAR directly prior to administer R5's scheduled morning eye drops. Nor did ULP-D document in R5's MAR that the medication had been administered directly following the above noted medication pass. On October 11, 2022, at 7:42 a.m., the surveyor asked ULP-D what her process was for documenting when medications had been administered. ULP-D stated she routinely checks the MARs in the morning and then completes all her morning medication passes for her residents assigned to her. Then after she has administered all the morning medications to all her assigned residents she goes to the computer and documents on all the residents at one time that all the medications had been administered. On October 11, 2022, at 9:22 a.m., registered nurse (RN)-C stated staff should check the resident's electronic MAR prior to administering medications; check the MAR with the number of pills in the planner to be administered at the scheduled time; administer the medications if the number of pills matches what is indicated on the MAR; if the count is not correct the staff should notify the RN before administering the medications. Directly after the staff have administered the medications, they should document in the resident's MAR that the medications have been administered. RN-C confirmed staff should not be documenting a group of residents' medication passes at one time. The licensee's Medication	01760		

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01760	Continued From page 21 Management-Administration and Setup policy dated July 1, 2021, noted ULP will verify medications are setup correctly in the dosage box before administering to the resident by use of the medication profile. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals. The licensee's Medication and Treatment-Administration and Delegation policy dated July 1, 2021, included the following medication administration procedure: - checking a resident's MAR - prepare the medications for administration - reminder to self-administer medications - document after assistance with medication reminder or medication administration No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures for two of two medication refrigerators (memory care and	01880		

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01880	Continued From page 22 assisted living). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 10, 2022, at approximately 1:35 p.m., registered nurse (RN)-C confirmed the licensee provided medication management services to the licensee's residents, including storage of medication. MEMORY CARE MEDICATION REFRIGERATOR On October 10, 2022, at 1:57 p.m., the surveyor and RN-C reviewed the contents of the medication refrigerator located in the memory care unit. RN-C was unable to locate a thermometer inside the refrigerator to confirm the current temperature of the refrigerator and commented, "that [temperature] is a good question". Licensed assisted living director (LALD)-A brought RN-C a thermometer for the memory care refrigerator, adding there were two thermometers in the other refrigerator. RN-C stated the recommended temperature for refrigerator medication storage was between 32 degrees Fahrenheit (F) to 42 degrees F. RN-C added the recording sheet would include what the temperature of the refrigerator should be. The surveyor requested a history of recorded	01880		

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01880	Continued From page 23 temperature logs for the memory care refrigerator to review. During the above observation, RN-C verified the memory care medication refrigerator contained: -14 prefilled syringes of Ativan (anxiety) 0.25 milliliters (ml) and a bottle containing 25 mls of Ativan for R3; -3 unopened Novolog (fast acting insulin) 100 units (U)/ml pens for R2; and -1 unopened Tresiba (long acting insulin) 100 U/ml pen for R2. The memory care temperature logs, dated September 21, 2022, through October 9, 2022, indicated the temperatures were recorded twice a day, results were as follows: -Line 1: 19 of the 19 opportunities for documenting refrigerator temperatures were recorded, and of the 19 opportunities, 12 were recorded as below 36 degrees F; and -Line 2: 19 of the 19 opportunities for documenting refrigerator temperatures were recorded, and of the 19 opportunities, 15 were recorded as below 36 degrees F. The daily refrigerator/freezer temperature log read, "refrigerator thermometer temperature will be kept at 35 degrees to 46 degrees F, or lower". ASSISTED LIVING MEDICATION REFRIGERATOR On October 10, 2022, at 2:17 p.m., the surveyor and RN-C reviewed the contents of the locked medication refrigerator for the assisted living residents. RN-C checked the thermometer inside the refrigerator and verified a reading of 36 degrees F. RN-C stated, "I don't know if we have a process to report temperatures out of range."	01880		

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01880	Continued From page 24 RN-C looked in RTask (on-line charting system) and said, "no we don't". The surveyor requested a history of recorded temperature logs to review for the assisted living refrigerator. During the above observation, RN-C verified the assisted living medication refrigerator contained: -2 unopened Levemir (long acting insulin) 100 U/ml pens for R6; -19 unopened Basaglar (long acting insulin) 100 U/ ml pens for R7; -3 unopened Trulicity (medication used weekly that helps body release it's own insulin) 0.75 milligrams (mg)/0.5 ml pens for R7; -6 unopened Lantus (long acting insulin) 100. U/ml pens for R8; -6 unopened Humalog KwikPen (quick acting insulin) 100 U/ml pens R8; -2 unopened Lantus 100 U/ml pens for R8; -1 unopened bottle and one opened bottle of Florajen acidophilus (aids in healthy functioning of the digestive tract) for R9; and -1 unopened bottle and one opened bottle of Florajen acidophilus for R5. The assisted living temperature logs, dated September 21, 2022, through October 9, 2022, indicated the temperatures were recorded twice a day, results were as follows: -Line 1: 19 of the 19 opportunities for documenting refrigerator temperatures were recorded, and of the 19 opportunities, 13 were recorded as below 36 degrees F; and -Line 2: 19 of the 19 opportunities for documenting refrigerator temperatures were recorded, and of the 19 opportunities, 9 were recorded as below 36 degrees F. The daily refrigerator/freezer temperature log read, "refrigerator thermometer temperature will	01880		

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01880	Continued From page 25 be kept at 35 degrees to 46 degrees F, or lower". On October 10, 2022, directly following the above observation RN-C reviewed the temperature logs for both refrigerators with the surveyor. RN-C verified the temperature readings were not in the acceptable range. The manufacturer's instructions for Ativan dated 2022, indicated protect from light, store refrigerated at 36 to 46 degrees F. The manufacturer's instructions for Novolog dated 2018, indicated unopened pens should be stored in the refrigerator, if frozen or overheated, throw it away. The manufacturer's instructions for Tresiba dated September 2022, indicated unused pens and vials should be stored in the refrigerator at 36 to 46 degrees F. The manufacturer's instructions for Levemir dated September 2022, indicated unused pens should be stored in the refrigerator at 36 to 46 degrees F. The manufacturer's instructions for Basaglar dated June 4, 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Trulicity pen revised September 2018, directed to store the pen in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Lantus insulin pens, dated March 2020, indicated store the insulin pens in the refrigerator between 36 to 46	01880		

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01880	Continued From page 26 degrees F. The manufacturer's instructions for Humalog insulin pens, dated June 4, 2021, indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for acidophilus, dated August 27, 2021, indicated manufactures recommend refrigerating probiotics, which can help keep the bacteria alive longer than storing them at room temperature. The licensee's Medication Storage policy revised July 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to monitor for expired medication for one of four residents (R12).	01890		

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01890	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 12, 2022, at 7:36 a.m., the surveyor observed unlicensed personnel (ULP)-E remove R12's morning medication from a locked medication cabinet and administer the medication to R12. The surveyor observed a container of ipratropium bromide (used to treat a runny nose/reducing the amount of fluid/mucus released inside the nose) 21 micrograms (mcg) in R12's medication cabinet that had expired February 2022. On October 11, 2022, at approximately 7:40 a.m., ULP-E commented she had never seen the above mentioned medication before. ULP-E stated she would talk to registered nurse (RN)-C about ipratropium bromide. ULP-E removed the medication from R12's medication cabinet. On October 11, 2022, at 7:44 a.m., RN-C verified ipratropium bromide had expired. RN-C stated she looked it (mentioned medication) up and the medication was ordered to be used as needed (PRN) for R12. RN-C added R12 was not currently using this medication and she would get an order to have ipratropium bromide discontinued.	01890		

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01890	Continued From page 28 The licensee's Expired Medication Plan policy revised May 18, 2022, indicated the RN/licensed practical nurse (LPN) were responsible for maintaining only current non expired medications for resident use, to include; -monthly audit of PRN medications provided by the facility. Scheduled monthly on R-task (on line system) for completion; -weekly audit if residents' prescription and over the counter (OTC) medications by nurse filling medications for weekly distribution by facility, utilizing best practices for nurses; -outdated medications would be reordered at residents' drug store of choice; and -any outdated medication would be placed in locked cabinet in administrator's office for disposal at local sheriff's office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 29 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of all medications to include the quantity for all medications for one of one discharged resident (R1). 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 admitted for services on November 19, 2021 and discharged on August 30, 2022. R1's Service Plan dated May 31, 2022, indicated the resident received medication management services which included medication administration and medication setup. R1's Discharge Summary dated August 30, 2022, indicated R1 moved to another facility, closer to family, and R1's medications were given to R1's	01910		

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01910	Continued From page 30 son to take to the new facility. R1's Current Medications at Discharge dated August 30, 2022, included the following medications: amlodipine (high blood pressure) 5 milligrams (mg) daily, aspirin (heart health) 81 mg daily, atorvastatin (hyperlipidemia/high cholesterol) 10 mg daily, donepezil (dementia) 5 mg at bedtime, finasteride (BPH-benign prostatic hyperplasia, overgrowth of prostate tissue blocking the flow of urine) 5 mg daily, levothyroxine (hypothyroidism) 125 micrograms (mcg) daily, memantine (dementia) 5 mg daily, sertraline (depression) 50 mg daily, tamsulosin (BPH) 0.4 mg daily, and vitamin C 500 mg daily. R1's prescriber orders dated November 22, 2021, included the above noted medications. R1's record lacked documentation of the quantity for all the medication sent with R1's son. On October 11, 2022, at 11:13 a.m., registered nurse (RN)-C verified R1's record did not include medication counts for any of the medications listed above. The licensee's Medication Disposal policy revised July 1, 2021, indicated the facility would 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 medication and controlled substances. In addition, 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	01910		

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01910	Continued From page 31 disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;	02110		

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02110	Continued From page 32 (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to two of two residents (R2, R4) and/or the resident's legal and designated representative. 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 held an assisted living with dementia care license and was licensed for a capacity of 42 residents. During the entrance conference on October 10, 2022, at 1:17 p.m., registered nurse (RN)-C stated they provided services for residents with dementia and were licensed as an assisted living facility with dementia care. R2 R2 was admitted to the memory unit for services on February 23, 2022.	02110		

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02110	Continued From page 33 R2's diagnoses included, diabetes, osteoarthritis, asthma (a condition in which a person' airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), anemia (condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues) and hypertension (HTN-high blood pressure). R2 received services under the licensee's assisted living with dementia care license. R4 R4 was admitted on December 6, 2021. R4's diagnoses included dementia, anemia, obstructive sleep apnea (intermittent airflow blockage during sleep), HTN and congested heart failure (CHF-a chronic condition in which the heart doesn't pump blood as well as it should). R4 received services under the licensee's assisted living with dementia care license. R2 and R4's records lacked evidence or documentation the residents/representative received the policies and procedures related to dementia care to be provided at the time of resident move-in to the facility. On October 11, 2022, at 2:19 p.m., licensed assisted living director (LALD)-A stated the dementia care policies had not been provided to the residents as required. The licensee's Assisted Living with Dementia Care Additional Required Policies policy revised July 2, 2021, indicated the facility had an Assisted	02110		

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02110	Continued From page 34 Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must address the following list: -philosophy of how services are provided based upon the assisted living facility license's values mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evaluation drills only;-transportation coordination and assistance to and from outside medical appointment; and -safekeeping of resident's possessions. In addition, these policies and procedures must be provided to resident and the resident's legal and designated representatives at the time of move-in. The polices can be provided in electronic format if desired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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02170	Continued From page 35	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 36 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan for one of one resident (R4) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held as an assisted living with dementia care license. R4's diagnoses included dementia, anemia (condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues), obstructive sleep apnea (intermittent airflow blockage during sleep), hypertension (HTN-high blood pressure) and congested heart failure (CHF-a chronic condition in which the heart doesn't pump blood as well as it should). R4's Individual Activity Plan dated October 3, 2022, included an evaluation of the activity areas which are required, however, did not include an individualized activity plan for R4. On October 12, 2022, at 10:48 a.m., registered nurse (RN)-C reviewed R4's Individual Activity Plan. RN-C stated the same Individual Activity	02170		

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02170	Continued From page 37 Plan was used for all residents to determine the resident's preferences, interests, and limitations. RN-C stated an individualized activity plan based off this evaluation had not been developed for R4, or any other resident as required. The licensee's ALDC (Assisted Living Dementia Care) Life Enrichment Programs, Activities, and Outdoor Spaces policy dated July 2, 2021, noted an individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with an assistive device (consumer bedrail) and one of one resident (R2) with hospital-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	02310		

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02310	Continued From page 38 or a violation that has the potential to lead to 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). This resulted in an immediate correction order on October 11, 2022, at approximately 11:25 a.m. The findings include: R4 On October 11, 2022, at 7:33 a.m., the surveyor observed R4 seated in a recliner in her room. R4's bed had a single upper u-shaped consumer purchased bedrail on the right side of the bed in the stationary upright position. R4 stated she uses the bedrail to help her get out of bed. R4's diagnoses included dementia, anemia (condition in which body lacks enough healthy red blood cells to carry adequate oxygen to body tissues), obstructive sleep apnea (intermittent airflow blockage during sleep), hypertension (HTN-high blood pressure) and congested heart failure (CHF-a chronic condition in which the heart doesn't pump blood as well as it should). R4's service plan dated June 5, 2022, indicated the resident received the following services: medication setup, medication administration, oxygen therapy, laundry, and housekeeping. R4's assessment dated October 3, 2022, indicated the resident is a fall risk, uses a walker to assist with ambulation and is on continuous oxygen therapy.	02310		

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	32429	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY	622 EAST 7TH STREET MORRIS, MN 56267

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02310	Continued From page 39 R4's record lacked a comprehensive assessment of the use of an assisted device (bedrail), including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. R4's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the bedrail. On October 11, 2022, at 9:50 a.m., registered nurse (RN)-C stated she was unaware R4 had a bedrail on her bed. RN-C stated an assessment had not been completed for R4 as required. On October 11, 2022, at 10:00 a.m., RN-C measure R4's bedrail. The inside of the u-shaped bedrail measured 14 inches wide and the distance between the bedrail and the mattress was three inches. The bedrail was held in place by bars placed between the mattress and the box spring and rachet straps attached to the bars under the mattress of the bedrail and went around and under the box spring coming back up the side of the box spring and attaching to the base of the bedrail. The bedrail appeared to be secure. RN-F stated the son had brought the bedrail in last Thursday (October 6, 2022). R2 R2 was admitted to the memory unit for services on February 23, 2022.	02310		

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02310	Continued From page 40	02310		

R2's diagnoses included, diabetes, osteoarthritis, asthma (a condition in which a person' airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), anemia and HTN.

R2's Service Plan dated May 31, 2022, indicated the resident received the following services, bathing assistance, toileting assist, transfer assist, cueing, dressing assist drinking assist, grooming, incontinence assist, laundry and housekeeping assist, meal escorts, medication administration, medication setup, and blood glucose monitoring (using a meter to determine the blood glucose blood level) two days a week.

On October 11, 2022, at 7:34 a.m., the surveyor observed unlicensed personnel (ULP)-E enter R2's room and hold a blood glucose meter up to sensor attached to R2's upper arm to get a blood glucose reading. R2 was observed lying partially sideways in a hospital bed, facing the wall. There was an upper bedrail was in the lowered position attached securely to R2's bed. R2 stated she was not sure if she used the bedrail or not.

On October 11. 2022, at approximately 9:30 a.m., a bedrail assessment was requested for R2. RN-C verified an assessment for bedrails was not completed for R2. RN-C added the family moved "that" bed in for R2 when R2 transferred from the assisted living unit to the memory care unit.

R2's record lacked a comprehensive assessment on the use of an assistive device and lacked bedrail measurements. R2's record lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative, and lacked information related to interventions implemented by the licensee to

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02310	Continued From page 41 mitigate the resident's risk for safety pertaining to the use of the device. On October 11, 2022, at ,10:41 a.m., RN-C measured R2's side rail with surveyor present. The bedrail measured 8 inches tall by 3 "inches wide and 2.5 inches tall by 17.5 inches long, which was in compliance with FDA guidelines for side rails. The licensee's Side Rails policy dated July 2, 2021, indicated the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. The side rails should be consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021,	02310		

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02310	Continued From page 42 identified a recall involving adult portable bedrails that do not have safety retention straps to secure the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310		

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02310	Continued From page 43 Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyor's on-site observation and review by evaluation supervisor on October 11, 2022, however, non-compliance remains at a scope and level of three, pattern (H). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure resident's personal health and medical information was kept private. This had	02430		

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02430	Continued From page 44 the potential to affect all five (5) residents residing in the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 11, 2022, at 8:26 a.m., the surveyor observed an opened lap top computer sitting on a desk in the commons area of the memory care unit. The computer screen displayed the names of residents residing in the unit and information pertaining to their care. On October 11, 2022, at 8:30 a.m., licensed assisted living director (LALD)-A verified the computer screen with names and personal information should not have been left in the open position. LALD-A stated she would remind the staff adding "we" [staff] normally minimize it [computer screen] or do like this, as LALD closed the screen most of the way down. LALD also said the computer screens on the assisted living (AL) side were not left "like that" [with information visible]. The licensee's Resident Record-Confidentiality policy revised July 7, 2021, indicated resident records would be kept confidential and locked in a secure area where only authorized staff of the facility had access to. No further information provided.	02430		

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02430	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *10/11/22*
Time: 08:10:53
Report: 7935221264

Food and Beverage Establishment Inspection Report

Location:
The Legacy
622 East 7th Street
Morris, MN56267
Stevens County, 75

Establishment Info:
ID #: 0038776
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202083070
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

EXPLAINED WHAT WAS NEEDED AND HOW TO USE DURING INSPECTION. ESTABLISHMENT IS GOING TO ORDER ONE.

Comply By: 11/30/22

2-100 Supervision

2-102.12AMN

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

SARAH HAS TAKEN SERVSAFE AND HAS ALSO TAKEN 4 HOURS CONTINUING EDUCATION. APPLICATION FOR STATE CERTIFICATION EMAILED TO DIRECTOR.

Comply By: 11/30/22

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

BULK FLOUR/SUGAR CONTAINERS. SARAH LABELED DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Hot Water: = at 166 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Arctic Air
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935221264 of 10/11/22.

Certified Food Protection Manager: Sarah Buntje

Certification Number: _____ Expires: / /

Signed: _____ Signed: 7935

Establishment Representative

7935

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