Electronically Delivered

May 19, 2023

Licensee
Scandia Senior Care, LLC
540 East Isle Street
Isle, MN 56342

RE: Project Number(s) SL28438015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions 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.

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28438	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA SENIOR CARE LLC	540 EAST ISLE STREET ISLE, MN 56342

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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: SL28438015 On May 1, 2023, through May 3, 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 ten (10) active residents all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 1, 2023, at 9:48 a.m., clinical nurse supervisor/licensed	0 250		

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0 250	Continued From page 3 assisted living director (CNS/LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250		

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by agent (A)-H on May 20, 2021. The licensee had an assisted living license issued on May 1, 2023, with an expiration date of April 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) orientation to and implementation of the assisted living bill of rights; (4) medication and treatment management; (5) delegation of tasks by registered nurses or licensed health professionals; (6) supervision of unlicensed personnel	0 250		

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0 250	Continued From page 6 performing delegated tasks. On May 3, 2023, at 12:28 p.m., CNS/LALD-A confirmed the licensee provided assisted living with dementia care but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0450, 0480, 0650, 0680, 0790, 0800, 0810, 0820, 1060, 1370, 1380, 1420, 1440, 1500, 1620, 1650, 1750, 1760, 1790, 1880, 1890, 1950, 1960, 2140, 2310, 2410, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;	0 450		

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0 450	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the residents and written acknowledgement received for two of three residents (R4, R6). This had the potential to affect all residents. 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 the residents). The findings include: The licensee had a current assisted living license with dementia care. R4 R4's diagnoses included altered mental status, atrial fibrillation (irregular, rapid heart rate), depression, and suprapubic urinary catheter (inserted through a hole in abdomen and directly into the bladder). R4's record included a signed copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. R6 R6's diagnoses included depression, diabetes, and pain.	0 450		

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0 450	Continued From page 8 R6's record included a signed copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. On May 3, 2023, at 11:28 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was having difficulty locating R6's updated Minnesota Bill of Rights. CNS/LALD-A stated, "I don't understand why it (bill of rights) was not here... it had just been updated a month ago.... the Bill of Rights is of part of the annual paperwork." Assistant director/unlicensed personnel (AD/ULP)-B stated she recently received a "new" bill of rights from a consultant. CNS/LALD-A stated she was not aware the Minnesota Bill of Rights had been updated. CNS/LALD-A said none of their residents had the current Minnesota Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
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	0 480		

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0 480	Continued From page 9 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 May 1, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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; (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	0 650		

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0 650	Continued From page 10 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 required content for three of three employees (unlicensed personnel/ULP-C, ULP-D, assistant director (AD)/ULP-B). 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: ULP-C ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C check R5's blood sugar and administer insulin and oral medication to R5. ULP-C's employee record did not include documentation of all required training outlined below. On May 2, 2023, at 11:02 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she verbally taught ULP-C	0 650		

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0 650	Continued From page 11	0 650		

and all other ULPs the following:
-reporting changes in the client condition to the supervisor designated by the facility;
-maintenance of a clean and safe environment;
-medication, exercise, and treatment reminders;
-basic knowledge of body function and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
-recognizing physical, emotional, cognitive, and developmental needs of the client;
-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;
-review of types of assisted living services the employee would provide and provider's scope of license; and
-review of provider's policies and procedures.

On May 1, 2023, directly following the above review, CNS/LALD-A said she verbally taught the above listed items. CNS/LALD-A stated she teaches all ULPs in the same manner. CNS/LALD-A said ULP-C's employee record did not contain evidence of all the required training.

ULP-D
ULP-D was hired on June 8, 2022, to provide direct care services to residents of the facility.

On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-D use a sit to stand lift (mechanical) to assist R4 out of bed and into a wheelchair.

ULP-D's employee record contained a Nurse Observation of Unlicensed Staff form dated June 17, 2022, a Nurse Observation Clearance for New Hires dated June 17, 2022, and a transcript

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0 650	Continued From page 12 from Educare (on-line learning). ULP-D's employee record did not contain the Protocols for (facility name) Training & Competency form which the facility used to track required training and competency in the required areas. On May 2, 2023, at 11:00 a.m., CNS/LALD-A stated ULP-G's employee record was missing the required training form. CNS/LALD-A stated ULP-G had received the necessary training, "sometimes they take it [the worksheet/paperwork] home with them and do not return it. On May 2, 2023, at approximately 11:10 a.m., ULP-G was interviewed by CNS/LALD-A in the presence of the surveyor. ULP-G stated she thought she had brought the paperwork back to the facility and it was in her employee record. AD/ULP-B AD/ULP-B was hired on August 3, 2014. AD/ULP-B's employee record contained a care attendant job description dated August 4, 2014. On May 1, 2023, at approximately 9:45 a.m., during the entrance conference AD/ULP-B stated she was the assistant director for the facility. On May 3, 2023, at 11:03 a.m., AD/ULP-B stated her employee record did not include a current job description, adding "I want one [current job description]. The licensee's Personnel Records policy dated April 24, 2023, indicated personnel records would be kept up-to date, well organized and	0 650		

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	28438	A. BUILDING: _____ B. WING _____	05/03/2023

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0 650	Continued From page 13 confidential and would comply with the assisted living law and other relevant laws. The personnel record for each person would include: -record of orientation; -record of all required training for unlicensed personnel and competency evaluations; and -current job description, which included qualifications, responsibilities, and identification of supervisors. 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 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	0 680		

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0 680	Continued From page 14 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 observation, interview and record review, the licensee failed have a written emergency preparedness plan (EPP) posted in a prominent area, and developed with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 1, 2023, at 11:33 a.m., during a tour of the facility with assistant director/unlicensed personnel (AD/ULP)-B and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, the surveyor did not observe the facility's EPP in a prominent area. The licensee's EPP last reviewed April 24, 2023, failed to include the following: -process for coordinating with other health care facilities (HCF) as well as community on a whole during emergency or disaster; -process for emergency preparedness (EP) cooperation with local, tribal, regional, state and	0 680		

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0 680	Continued From page 15 local EP officials/organizations; -process for sheltering in place for staff/residents; - procedures for tracking of staff and patients; and -developing a communication plan with all the necessary requirements. On May 1, 2023, at 12:40 p.m., AD/ULP-B and CNS/LALD-A stated the facility's EPP did not contain all the required information. CNS/LALD-A stated the facilities EPP was "in process." The licensee's Emergency and Disaster Preparedness policy dated 24, 2023, indicated the EPP would address the following requirements: -addresses our resident population, including, but not limited to persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operation, including delegations of authority and succession plans; -includes a process for cooperation and collaboration with local, tribal, regional, State or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation; the emergency disaster plan contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocating sites, and details staff assignment in the event of a disaster or an emergency; -a written communication plan is complete that addresses the elements listed in 42 C.F.R.483.73 (c); our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R 483.73 (c); and -the facility would post the emergency disaster plan prominently.	0 680		

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0 680	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide adequately rated and maintained portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 790		

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0 790	Continued From page 17 a large portion or all of the residents). Findings include: On a facility tour on May 2, 2023, at approximately 12:00 p.m. with maintenance (M)-E it was observed that several fire extinguishers provided were only B:C rated and one 3-A:40-B:C was provided but not maintained as required by MN Statute 144G.45. At least one 2-A:10-B:C rated fire extinguisher located within 75' of travel throughout the facility is required to be installed and maintained according to MN Statute 144G.45. M-E visually verified this deficient finding at the time of discovery. 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and	0 800		

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0 800	Continued From page 18 well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 2, 2023, at approximately 12:30 p.m. with maintenance (M)-E it was observed the public (resident) shower room/ restroom in the new addition was not open for use and was under repair/ construction. During the tour it was stated by M-E the restroom shower was under repair because of water leaking from the shower in and through the wall dividing the shower stall from the remainder of the bathroom. Survey staff advised M-E during the facility tour to complete a construction submittal form and submit to MDH. This deficient condition was visually verified by M-E accompanying on the 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:	0 810		

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0 810	Continued From page 19 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 20 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 potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on May 2, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-A and assistant director (AD)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee included general employee actions but did not include specific and detailed employee actions to be taken in the event of a fire or similar emergency related to this facility. During the interview LALD-A indicated the fire safety and evacuation plan lacked detail for evacuation related to this specific facility. Record review of the available documentation indicated that the licensee did not have detailed fire protection procedures necessary for residents located in writing within the plan. During the interview LALD-A and AD-B indicated these procedures were not included in the plan because it is a dementia care facility. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. At the time of the interview training materials were	0 810		

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0 810	Continued From page 21 verbally presented by LALD-A and AD-B and it was stated that the training was completed but written documentation was not available. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. During the interview LALD-A and AD-B provided insufficient documentation that drills had been completed twice per shift per year and at least every other month. All deficiencies were verified by LALD-A and AD-B during the interview at approximately 11:00 a.m. 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	0 820		

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0 820	Continued From page 22 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to 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 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 a facility tour on May 2, 2023, at approximately 12:00 p.m. with maintenance (M)-E, it was observed the marked exterior exit doors were provided with locks that required a key code to unlock from the interior in order to exit the facility. During the tour M-E indicated the marked exterior exit door locks were not fail safe so that activation of a fire alarm system, fire sprinkler system or loss of power releases the door lock for the purpose of exiting in the event of an emergency. Please consult local fire authority or MN State Fire Marshal for compliance with special locking arrangements such as this for exit doors. It was also observed an exterior exit gate from	0 820		

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0 820	Continued From page 23 the secure outdoor deck area was provided with padlock hardware and a padlock that required a key for egress. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors. All clinical staff are required to carry a key or keypad combination to release the latch of the secured gate for egress. These deficient conditions were verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) 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	01060		

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01060	Continued From page 24 (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 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 required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R4, 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	01060		

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01060	Continued From page 25 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: R4 R4's diagnosis included atrial fibrillation (irregular, rapid heart rate), altered mental status, depression, suprapubic urinary catheter. R4's service plan dated September 14, 2022, noted to see care plan, for services provided. R4's care plan dated March 13, 2023, through March 31, 2023, included, dressing/grooming assist, bathing assist, continence care, diet assist, transfer assist, wheelchair assist, laundry and housekeeping services. R4's Nursing/Progress Notes dated January 10, 2023, noted, resident sent to hospital on January 7, 2023. She was admitted (to hospital) due to heart failure. R4's Nursing/Progress Notes dated January 13, 2023, noted, resident readmitted to facility on January 12, 2023. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - 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;	01060		

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01060	Continued From page 26 - 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. In addition, R4's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On May 2, 2023, at 1:54 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated OOLTC had not been contacted regarding R4's leave. R3 R3's diagnosis included hypertension, asthma, kidney disease, and heart disease. R3's medication management plan: addendum to service plan dated March 22, 2023, included medication administration daily. R3's treatment plan: addendum to service plan dated January 20, 2023, included continuous oxygen therapy to increase resident breathing comfort. On May 2, 2023, at 7:45 a.m., the surveyor observed ULP-C administer R3's morning oral medications and inhaler. R3's Nursing/Progress Notes dated March 7, 2023, noted, sent R3 to ER (emergency room), able to secure resident stay at psych unit after being seen in ER. R3's Nursing/Progress Notes dated March 22, 2023, noted, resident returned from geriatric	01060		

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01060	Continued From page 27 psych unit. R3's record lacked a written notice that contained, 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 OOLTC; - 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; - 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. On May 2, 2023, at 2:02 p.m., CNS/LALD-A stated OOLTC had not been contacted regarding R3's leave. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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; (3) basic infection control, including blood-borne	01370		

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01370	Continued From page 28 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 and competency was completed for one of one unlicensed personnel (ULP-C) to include all required content.	01370		

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01370	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 7:16 a.m., the evaluator observed ULP-C check R5's blood sugar, administer insulin and oral medication to R5. ULP's C employee record lacked documentation of competency evaluations for the following topics: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aides; - dressing and assisting with toileting; and -standby assistance techniques and how to perform them. On May 1, 2023, at 11:02 a.m., clinical nurse supervisor/licensed assisted living director CNS/LALD-A said the training received by ULP-C was a combination of Educare (on-line) training and verbal. CNS/LALD-A stated ULP-C's employee record did not contain documentation of the competencies listed above. In addition, CNS/LALD-A added she had an unidentified licensed practical nurse (LPN) whom she trusted to do the training for ULP-C. CNS/LALD-A stated the above listed topics did not have a competency evaluation performed by a RN.	01370		

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01370	Continued From page 30 The licensee's Assisted Living Orientation-ULP Staff policy dated April 17, 2023, indicated in addition to training all staff receive, ULPs who are not a registered nursing assistant would receive additional training on the following topics with a written or oral competency test and skills demonstrations: -hair care; -bathing; -care of teeth, guns (sic), and oral prosthetic devices; -care and use of hearing aids; -dressing; -assisting with toileting; and -standby assistance techniques. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	01380		

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01380	Continued From page 31 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-C) to include all required content. 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: ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 7:16 a.m., the evaluator observed unlicensed personnel (ULP)-C check R5's blood sugar and administer insulin to R5. ULP's C employee record lacked documentation of competency evaluations for the following topics: -reading and recording temperature, pulse and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; and -administering medications and/or treatments as required.	01380		

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01380	Continued From page 32 ULP-C's employee record included Medication Pass Observation Audit tool, dated March 8, 2023, signed by registered nurse (RN)-F. The form was completed during medication administration for R8 and indicated proper protocol in Medication Administration Record (MAR) for R8. On May 1, 2023, at 11:02 a.m., clinical nurse supervisor/licensed assisted living director CNS/LALD-A said the training received by ULP-C was a combination of Educare (on-line) training and verbal training. CNS/LALD-A stated ULP-C's employee record did not contain documentation of the competencies listed above. In addition, CNS/LALD-A stated she had an unidentified licensed practical nurse (LPN) whom she trusted do the training for ULP-C. The licensee's Assisted Living Orientation-ULP Staff policy dated April 17, 2023, indicated in addition to training all staff receive, ULPs who are not a registered nursing assistant would receive additional training on the following topics with a written or oral competency test and skills demonstrations: -reading and recording temperature, pulse and respirations of the resident; -safe transfer techniques and ambulation; -range of motion; -positioning; and -administering medications and/or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01420	Continued From page 33	01420		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of two unlicensed personnel (ULP-C). 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:	01420		

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01420	Continued From page 34 ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 6:56 a.m., ULP-C said she received her training from unidentified licensed practical nurse (LPN). ULP-C stated vital sign monitoring, transfers, and ostomies were included in training she received from LPN. On May 2, 2023, at 7:16 a.m., the evaluator observed ULP-C check R5's blood sugar using a FreeStyle blood glucose (BG) monitoring system, administer insulin and oral medication to R5. ULP's C employee record lacked documentation of competency evaluations for the following topics completed by a RN: -monitoring vital signs; -sit to stand (mechanical) lift; and -catheter/ suprapubic (a hollow flexible tube which is inserted via an incision in the lower abdomen and used to drain urine from the bladder). ULP-C's employee record included Protocols, Training & Competency form dated January 16, 2023 noted the following tasks initialed by LPN: -blood pressure -oxygen saturation -pulse -temperature On May 3, 2023, at 10:16 a.m., clinical nurse supervisor/licensed assisted living director (CNS-LALD)-A stated ULP-C's training was not completed by an RN. CNS/LALD-A added she was not working at the site at time, she had taken a leave. CNS-LALD-A stated she trusted the unidentified LPN who did the training on "everything" (vital signs, catheters, sit to stand	01420		

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01420	Continued From page 35 lifts) for ULP-C. CNS/LALD-A stated she later signed the training form. The licensee's Delegation of Nursing Tasks policy dated April 17, 2023, indicated ULP may perform nursing care series beyond their usual and customary roles if delegated by the RN and would perform these tasks under the supervision of a RN. The RN would verify the ULP was trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident; if the ULP was not trained, the RN would provide training in-person, verbally, or through other acceptable methods. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 36 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-C. 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: ULP-C was hired on January 5, 2023, to provide direct care services to residents at the assisted living with dementia care facility. On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C obtain R5's blood glucose level and administer R5's morning insulin injections. ULP-C's employee record included "Nurse Observation Clearance for New Hires" dated	01440		

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01440	Continued From page 37 January 16, 2023, signed by an unidentified licensed practical nurse (LPN). ULP-C's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On May 2, 2023, at approximately 10:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-C's 30-day supervision of performing a delegated task had not been completed as required. CNS/LALD-A said she was not working at the facility at the time, adding a LPN completed ULP-C's supervision of staff performing a delegated task form and authenticated the form. CNS/LALD-A stated she later co-signed the form. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated April 17, 2023, indicated supervision of ULPs by an RN would be direct supervision of the staff performing a delegated task (s) within 30 calendar days after the staff member began working and first performed the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500		

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01500	Continued From page 38	01500		

provision of assisted living services. The annual training must include:
(1) training on reporting of maltreatment of vulnerable adults under section 626.557;
(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.
(b) In addition to the topics in paragraph (a), annual training 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

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01500	Continued From page 39 challenges it poses to communication; (2) the 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 an employee received all of the required annual training content for each 12 months of employment for one of one employee (unlicensed personnel (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 a large portion or all of the residents). The findings include: ULP-G started employment on October 9, 2015, and began providing assisted living services on August 1, 2021. On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-G push R4's wheelchair into a bathroom and empty R4's catheter into the toilet.	01500		

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01500	Continued From page 40 ULP-G's employee record lacked evidence ULP-G successfully completed annual training as required to include: - a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On May 3, 2023, at 10:08 a.m., assistant director/unlicensed personnel (AD/ULP)-B stated ULP-G's annual training did not include a review of policies and procedures. AD/ULP-B stated it was "fair" to say a review of the facilities policies and procedures had not been completed in the annual training for any of the staff. The licensee's Assisted Living With Dementia Care Annual Training dated April 17, 2023, indicated all assisted living employees would complete annual education on the following topics: -review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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01620	Continued From page 41 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 for three of three residents (R4, R7, R10). 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:	01620		

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01620	Continued From page 42 R4 R4 began receiving assisted living services on September 15, 2021. R4's diagnosis included atrial fibrillation (irregular, rapid hear-rate), altered mental status, depression, and suprapubic urinary catheter (catheter inserted through abdomen directly into bladder.) R4's service plan dated September 14, 2022, noted to see care plan, for services provided. R4's care plan dated March 13, 2023, through, March 31, 2023, included: medication administration, transfer/positioning assist, dressing assist, assist with mobility, stoma site care, suprapubic catheter care, laundry and housekeeping services. On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-G push R4's wheelchair into a bathroom and empty R4's catheter into the toilet. R4's record included an admission assessment completed September 15, 2021; and - a reassessment (14 day) assessment completed on October 13, 2021 (14 days overdue) R7 R7 began receiving assisted living services on June 22, 2022. R7's diagnosis included hypertension. R7's service plan dated June 22, 2022, noted to see care plan, for services provided. R7's care plan dated April 1, 2023, through April	01620		

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01620	Continued From page 43 30, 2023, indicated R4 received the following services: continence care supervision, transferring supervision, medication administration, laundry and housekeeping services. On May 2, 2023, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R7's morning oral medications and inhaled medication. R7's record included an admission assessment completed on June 22, 2022; and - a reassessment (14 day) assessment completed on September 14, 2022 (70 days overdue) R10 R10 began receiving assisted living services on October 4, 2022, R10's diagnosis included depression, and dementia. R10's service plan dated October 4, 2022, noted to see care plan, for services provided. R10's care plan dated April 1, 2023, through April 30, 2023, noted R10 received the following services: dressing assist, supervision with continence care, medication administration, walking/wheeling, laundry and housekeeping. On May 2, 2023, at 8:42 a.m., the surveyor observed ULP-G apply compression stockings (TEDs) to R10's legs. R10's record included an admission assessment completed admission assessment was completed on October 8, 2022; and	01620		

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01620	Continued From page 44 -a reassessment (14 day) assessment completed on November 16, 2022 (25 days overdue) On May 3, 2023, at 10:53 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R4, R7, and R10's assessments were not completed as required. CNS/LALD-A said, "Yep, that has fallen short." The licensee's Initial and On-Going Nursing Assessment of Resident policy dated April 17, 2023, noted a RN would complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: -pre-admission assessment; -14-day assessment; completed up to 14-days after start of services; -ongoing assessments; completed periodically but no less than every 90-days; and -change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 45 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R4). This had the potential to affect all residents who received services at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01650		

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01650	Continued From page 46 R4 began receiving assisted living services on September 15, 2021. R4's diagnosis included atrial fibrillation (irregular, rapid heart-rate), altered mental status, depression, and suprapubic urinary catheter (catheter inserted through abdomen directly into bladder.) R4's service plan dated September 14, 2022, noted to see care plan, medication plan, and treatment plan for services provided. R4's care plan dated March 13, 2023, through, March 31, 2023, included: medication administration, transfer/positioning assist, dressing assist, assist with mobility, stoma site care, suprapubic catheter care, laundry and housekeeping services. On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-G push R4's wheelchair into a bathroom and empty R4's catheter into the toilet. R4's service plan dated September 14, 2022, did not include: - the method of monitoring assessments of the resident: and -the method of monitoring staff providing services. On May 2, 2023, at 3:01 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated all of the resident's service plans were missing the above requirements. CNS/LALD-A added updating the service plans was "in process" as they have the new service plans but have not yet implemented them. The licensee's Contents of Service Plans policy,	01650		

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01650	Continued From page 47 dated April 17, 2023, noted service plans would include: -schedule and methods of monitoring assessments; and -schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=E	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: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for one of two employees (ULP-C). In addition, the licensee failed to provide specific resident	01750		

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01750	Continued From page 48 instructions relating to the administration of medications for two of three residents (R5, 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 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: COMPETENCY DEMONSTRATION ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 6:56 a.m., ULP-C stated she received her training from unidentified licensed practical nurse (LPN) which included medications. On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C check R5's blood sugar, administer insulin using an insulin pen and administer oral medications to R5. ULP-C's employee record contained Protocols for (name of facility) dated January 16, 2023, training and competency form which included: Medication Pass: -med pass guidelines: Educare (on-line learning); -controlled medications: Educare -ear drops: Educare; -eye drops: Educare; -eye ointment: Educare; -enemas, inhalers: Educare;	01750		

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-gastrostomy, nebulizer: Educare;
-inhalants: Educare;
-insulin pen injections: Educare;
-liquids: Educare;
-nasal: Educare;
-oral: Educare; and
-PRN's medication (as needed or desired): Educare

ULP-C's employee record contained an Educare transcript that included:
-medication administration, overview dated January 11, 2023;
-medication routes, dated January 11, 2023;
-medication and treatment, insulin dated January 11, 2023;
-medication and treatment, insulin pens dated January 14, 2023;
-medication and treatment, nebulizer and inhalers: dated January 11, 2023.

ULP-C's employee record included Nurse Observation Clearance for New Hires dated January 16, 2023, authenticated by unidentified LPN and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A which included:
-washed hands before passing medication;
-oral medication;
-initials after giving medication;
-circles initial if refused/held/dropped and give clarification on back of page;
-as needed (PRN) documented on PRN sheet and makes note on communication sheet for staff/ nurse; and
-narcotic counting must be done together at shift change.

ULP-C's employee record included Medication Pass Observation Audit tool, dated March 8,

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01750	Continued From page 50 2023, signed by registered nurse (RN)-F. The form was completed during medication administration for R8 and indicated proper protocol in Medication Administration Record (MAR) for R8. On May 2, 2023, at approximately 11:00 a.m., CNS/LALD-A stated the training received by ULP-C was a combination of Educare training and verbal. On May 3, 2023, at 10:16 a.m., CNS-LALD-A stated ULP-C's competency training was not completed by an RN. CNS/LALD-A said she was not working at the site at time, adding she had taken a leave. CNS/LALD-A stated she trusted the unidentified LPN who did the training and competency evaluation on "everything" [medications] for ULP-C. CNS/LALD-A stated she later signed the training form, adding she did not do the training/ competency evaluation for ULP-C. The licensee's Training Unlicensed Personnel For Medication, Treatment and Therapy Administration dated April 17, 2023, indicated the RN would instruct and competency test the unlicensed personnel on the following topics and tasks before delegating to them the task of medication administration, treatment and therapy; -the 6 rights of administration; -infection control techniques that must be followed when administering medications treatment and therapy including hand washing and the use of gloves when appropriate; -the complete procedure for checking a resident's record and the nurse's written procedures specific to the resident for the administration of any delegated tasks. This included procedures for administration of any over-the counter	01750		

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01750	Continued From page 51	01750		

medications, PRN medications or dietary supplements, treatment and therapy, out facility had agreed to provide for the resident:
-procedures for the proper methods to administer medications, treatment and therapy to the resident;
-how to document services provided for the resident consistent with our agency's MAR documentation procedure: and
-the type of information reportable to a nurse regarding assistance or administration of medications, treatment and therapy including side effects, effectiveness, refused or help medications and medication errors and provision of treatment and therapy.
In addition, the RN would document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record.

The licensee's Training Licensed Personnel for Medication, Treatment and Therapy Administration policy dated April 17, 2023, indicated before the RN delegated the task of assistance with self-administration of medication or the task of medication administration, treatment and therapy the RN would instruct the ULP on performing these tasks and determine the ULP as competent to perform the tasks. The RN would document the training and competency of ULP to competently administer each type of service they are assigned in the staff person' personnel record.

SPECIFIC INSTRUCTIONS
R5
R5's diagnoses included diabetes.

R5's service plan dated March 30, 2023, noted to

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01750	Continued From page 52 see care plan, medication plan, and treatment plan for services provided. R5's medication management plan dated March 23, 2023, noted R5 received medication administration daily. On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C check R5's blood sugar using a FreeStyle blood glucose (BG) monitoring system, administer insulin and oral medication to R5. R5's MAR dated April 1, 2023, through April 30, 2023, included: -insulin lisp inj (injection) 100 units/milliliter (ml), inject 6 units subcutaneously three times daily before meal, 8:00 a.m., 12:00 p.m., 5:00 p.m. R5's treatment plan dated March 29, 2023, included glucometer checks three times daily, goal monitor and stabilize blood glucose levels on-going. On May 2, 2023, at 1:38 p.m., CNS/LALD-A stated specific information was in their "protocols." CNS-LALD-A said R5's MAR did not contain specific information for R5's insulin related to blood glucose levels. R3 R3's diagnosis included hypertension, asthma, kidney disease, and heart disease. R3's service plan dated March 22, 2023, noted to see care plan, medication plan, and treatment plan for services provided. R3's medication management plan dated January 20, 2023, noted R3 received medication administration daily.	01750		

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01750	Continued From page 53 On May 2, 2023, at 7:45 a.m., the surveyor observed ULP-C administer R3's oral medication with apple sauce. ULP-C handed R3 a Trelegy 100 microgram (mcg) inhaler and R3 put the inhaler up to their mouth and inhaled. R3's medication administration record dated April 1, 2023, through April 30, 2023, included: -Trelegy Ellipta 100-62.5-25 mcg one inhalation daily. On May 3, 2023, at 9:37 a.m., assistant director/ULP (AD/ULP)-B stated R3's MAR did not contain "rinse mouth after use", adding the pharmacy normally puts that information on the MAR. CNS-LALD-A stated R3's record did not contain specific information for R3's Trelegy inhaler. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated April 17, 2023, indicated the RN had developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750		
01760 SS=F	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	01760		

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01760	Continued From page 54 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 two employees, (unlicensed personnel (ULP)-C). In addition, the licensee failed to ensure medications were administered according to manufacturer's instructions for two of two residents (R3, R7) with inhalers. Further, the licensee failed to ensure documentation as to why a medication was not given and failed to include documentation to include the effectiveness for as needed (PRN) medication administration for one of two residents (R9). 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: FOLLOWING THE STEPS OF THE MEDICATION ADMINISTRATION PROCESS	01760		

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01760	Continued From page 55 ULP-C On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C remove R5's morning medication from the locked medication cart. ULP-C initialed off on each medication as she removed them from the medication cart. Directly following the above observation ULP-C stated she got into a routine documenting after each medication is "popped" out of the card. ULP-C added she was not trained to document that way; she was trained to document after medications were administered. Medication for R5 were documented by ULP-C as being administered prior to the medications being administered. On May 2, 2023, at 2:12 p.m., assistant director/ULP (AD/ULP)-B stated documentation of medication administration was to be completed after medications were administered. FOLLOWING MANUFACTURER'S INSTRUCTIONS R3 R3's diagnosis included hypertension, asthma, kidney disease, and heart disease. R3's service plan dated March 22, 2023, noted to see care plan, medication plan, and treatment plan for services provided. R3's medication management plan dated March 22, 2023, noted R3 received medication administration daily. R3's medication administration record (MAR) dated April 1, 2023, through April 31, 2023,	01760		

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01760	Continued From page 56	01760		

included Trelegy Ellipta 100-62.5-25 micrograms (mcg) one (1) inhalation daily, 8:00 a.m.

On May 2, 2023, at 7:45 a.m., the surveyor observed ULP-C administer R3's morning oral medication. ULP-C handed R3 her Trelegy Ellipta inhaler and R3 inhaled the medication. The surveyor did not observe R3 rinse her mouth out or drink any water after the inhaler, nor did the surveyor observe ULP-C remind R3 to rinse her mouth after the administration of the Trelegy Ellipta inhaler.

On May 3, 2023, at 9:37 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated residents should rinse their mouth after inhaling Trelegy. CNS/LALD-A added the pharmacy normally puts instructions on the MAR for staff to follow.

The manufacturer's instructions for use of the Trelegy Ellipta inhaler dated December 2022, indicated users should rinse their mouth with water after use and spit the water out. Do not swallow the water.

R7
R7's diagnosis included hypertension, asthma, and heart disease.

R7's service plan dated June 22, 2022, noted to see care plan, medication plan, and treatment plan for services provided.

R7's care plan dated April 1, 2023, through April 30, 2023, included medication administration by trained home health aides two (2) times daily.

R7's MAR dated May 1, 2023, through May 2, 2023, included Advair 250/50 mcg inhale one (1)

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01760	Continued From page 57 puff orally two (2) times daily (rinse mouth after each use); 8:00 a.m., 5:00 p.m. On May 2, 2023, at 8:12 a.m., the surveyor observed ULP-G administer R7's morning oral medications with coffee. ULP-G then handed R7 her Advair inhaler and R7 inhaled the medication. ULP-G said, "there you go" and wiped off the inhaler with a tissue. The surveyor did not observe R7 rinse her mouth out after inhaler use nor did the surveyor observe ULP-G remind R7 to rinse her mouth after the administration of the Advair inhaler. Directly following the above observation ULP-G stated R7 will rinse her mouth out later, "she always does." On May 2, 2023, at approximately 1:45 p.m., CNS/LALD-A stated staff should be "seeing" R7 is rinsing her mouth out and that ULPs should be following the directions on the MAR. The manufacturer's instructions for use of the Advair Diskus inhaler dated December 2021, indicated the user should rinse their mouth with water after use and spit the water out. Do not swallow the water. MEDICATION GIVEN AS PRESCRIBED R9 R9's diagnosis included atrial fibrillation (irregular, rapid heart-rate), and congestive heart failure (CHF.) R9's service plan dated March 1, 2022, noted to see care plan, medication plan, and treatment plan for services provided. R9's care plan dated March 1, 2023, through	01760		

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01760	Continued From page 58 March 31, 2023, noted R9 received medication administration three (3) times daily. R9's provider's ordered dated November 29, 2022, included: -acetaminophen 500 milligrams (mg) two (2) at bedtime; -famotidine (heartburn) 20 mg twice daily; -ferrous sulfate (anemia/low levels of iron in the blood) 325 mg daily; -folic acid (health supplement/ to prevent deficiency)1 mg daily; -gabapentin (nerve pain) 100 mg twice daily; -levothyroxine (thyroid) 125 mcg morning; -hydrocortisone (inflammation) 10 mg twice daily; -lortadine (allergies) 10 mg daily; and -risperidone (depression) 0.125 mg at bedtime. R9's April 1, 2023, through April 30, 2023, MAR documentation included the above medications, in addition: -27 of 30 opportunities acetaminophen was noted on the MAR, two (2) times there was no documentation the medication was given as prescribed; -9 of 60 opportunities famotidine was noted on the MAR, six (6) times there was no documentation the medication was given as prescribed and there were two (2) circles with no documentation of why the medication was not given as prescribed; -27 of 30 opportunities ferrous sulfate was noted on the MAR, one (1) time there was no documentation the medication was given as prescribed, and there were two (2) circles with no documentation of why the medication was not given as prescribed; -27 of 30 opportunities folic acid was noted on the MAR, one (1) time there was no documentation the medication was given as prescribed, and	01760		

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01760	Continued From page 59 there were two (2) circles with no documentation of why the medication was not given as prescribed; -7 of 30 opportunities gabapentin was noted on the MAR, six (6) times there was no documentation the medication was given as prescribed, and one (1) circle with no documentation of why the medication was not given as prescribed; -8 of 60 opportunities hydrocortisone was noted on the MAR, six (6) times there was no documentation the medication was given as prescribed and there was one (1) circle with no documentation of why the medication was not given as prescribed; -3 of 30 opportunities levothyroxine was noted on the MAR, two (2) times there was no documentation the medication was given as prescribed, and there was one (1) circle with no documentation of why the medication was not given as prescribed; -2 of 30 opportunities loratidine was noted on the MAR, one (1) time there was no documentation the medication was given as prescribed and there was one (1) circle with no documentation of why the medication was not given as prescribed; and -5 of 30 opportunities risperidone was noted on the MAR, four (4) times there was no documentation the medication was given as prescribed. PRN MEDICATION R9's April 1, 2023, through April 30, 2023, MAR included PRN Benadryl Cream 1-0.1% apply to affected areas four (4) times daily. - April's MAR stated PRN Benadryl cream was applied on April 7, April 23, and April 24. R9's record did not include any documentation for April 7, 2023, for Benadryl Cream.	01760		

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01760	Continued From page 60 R9's April 1, 2023, through April 30, 2023, MAR included Triamcinolone Cream 0.1 % apply a small amount to affected area on legs two (2) times daily PRN. - April's MAR noted PRN Triamcinolone cream was applied on April 13, April 23, and April 24, 2023. R9's record did not include any documentation for April 23 or April 24, 2023, for Triamcinolone Cream. On May 3, 2023, at 9:22 a.m., CNS/LALD-A stated if there were holes in the MAR it "usually means" staff forgot to document. CNS/LALD-A confirmed staff should be documenting each time a medication was given and if/when a medication was not given, it should be circled and an entry should be written as to why the medication was not given as prescribed. CNS/LALD-A added ULPs were not following the five (5) rights "whatever." CNS/LALD-A also stated ULPs should be documenting effectiveness of PRN medications. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated April 14, 2023, indicated staff would document each task immediately after that task had been performed. To include authentication with the name, title of the person making the entry. The licensee's Training Unlicensed (sic) Personnel For Mediation, Treatment and Therapy Administration policy dated April 17, 2023, indicated the complete procedure for checking a resident's record and the nurse's written procedures specific to the resident for the administration of any delegated tasks. This included procedures for administration of any over-the-counter medication, PRN medications or	01760		

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01760	Continued From page 61 dietary supplement, treatment and therapy, our facility had agreed to provide for the resident. The procedures for the proper methods to administer medications, treatment and therapy to the resident, and how to document services provided for the resident consistent with our agency's MAR documentation procedure. The licensee's Administration and Documentation of PRN medication dated April 17, 2023, indicated the registered nurse (RN) would document in the MAR the PRN medication name, symptoms for which the PRN medication may be administered, dose, route, frequent, where it was stored, when the supervising nurse needs to be notified and whether staff must check back with the resident following administration to determine whether the PRN was effective, and if so, the length of time after administration when the staff must check with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790		

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01790	Continued From page 62 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790		

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01790	Continued From page 63 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-C) was trained by registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on January 5, 2023, to provide direct care services to residents of the facility. On May 2, 2023, at 7:16 a.m., the surveyor observed ULP-C check R5's blood sugar, administer insulin and oral medications to R5. ULP-C's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide	01790		

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01790	Continued From page 64 medications to residents for unplanned times away from home by an RN. On May 3, 2023, at 11:02 a.m., clinical nurse supervisor/licensed assisted living director CNS/LALD-A stated the training received by ULP-C was a combination of Educare (on-line) training and verbal. CNS/LALD-A stated she had an unidentified licensed practical nurse (LPN) whom she trusted do the training for ULP-C. CNS/LALD-A confirmed ULP-C's training for medications was done by an LPN. The licensee's Delegation of Medications to Be Given To Residents By Unlicensed Staff for Residents Time Away From Home policy dated April 17, 2023, indicated one unlicensed staff that had been trained and had satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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:	01880		

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01880	Continued From page 65 Based on observation, interview and record review, the licensee failed to ensure medications were secured in a locked area for two of ten residents (R4, R8). In addition, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one of one medication refrigerator. 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). SECURE MEDICATION STORAGE R4 On May 1, 2023, at 10:34 a.m., the surveyor observed a locked medication cabinet in the upstairs nurse's office. On top of the locked cabinet were 30 nitroglycerin 0.2 milligram (mg)/hour patches for R4. Directly following the above observation assistant director/unlicensed personnel (AD/ULP)-B stated the patches were to be destroyed adding all medication should be locked up, to include the nitroglycerin patches. R8 On May 1, 2023, at 10:47 a.m., the surveyor reviewed the content of the locked refrigerator in the upstairs nurse's office with AD/ULP-B. AD/ULP-B confirmed there were 2 hydrocodone (5 mg codeine/325 mg acetaminophen) tablets (schedule II narcotic/high potential for abuse, with	01880		

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01880	Continued From page 66 use potentially leading to severe psychological or physical dependence) in the single locked refrigerator for R8. Directly following the observation clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the door leading up to the nurse's office was to be locked when not in use and there was a lock on the refrigerator, creating a double lock system. On May 2, 2023, at 6:50 a.m., the surveyor observed the door to the upstairs nurse's office unlocked and opened. On May 2, 2023, at 9:48 a.m., CNS/LALD-A said the door to the upstairs nurse's office was to be locked when not in use, adding the door should not have been unlocked and open. CNS/LALD-A stated the narcotics stored in the locked refrigerator were not double locked when the upstairs door was left unlocked. The licensee's Controlled Substances/Scheduled II Drugs policy dated April 24, 2023, noted all narcotic medications at the assisted living facility were stored double locked in the medication cart and in other double locked storage locations. MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On May 1, 2023, at 10:45 a.m., the surveyor reviewed the content of the locked medication refrigerator located in the upstairs nurse's office with AD/ULP-B. AD/ULP-B verified the internal refrigerator thermometer indicated the current temperature of the medication refrigerator was 37.4 degrees Fahrenheit (F). AD/ULP-B stated the refrigerator's temperature should be between	01880		

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01880	Continued From page 67 34-40 degrees F. The medication refrigerator temperature logs from March 16, 2023, through April 28, 2023, indicated the following: -the temperature was recorded 32 of 43 opportunities; and -31 of the 32 opportunities indicated temperatures below 36 degrees F. On May 1, 2023, at 10:47 a.m., the surveyor and AD/ULP-B observed and confirmed the contents of the medication refrigerator included the following medications; -one (1) unopened latanoprost eye solution 0.005% -one (1) unopened vital naloxone 0.4 mg -two (2) hydrocodone 5/325 mg tablets -a partial bottle of alprazolam 0.25 mg -50 alprazolam 0.25 mg tablets -85 Clonazepam 0.5 mg -seven (7) unopened lispro 100 units/ml insulin pens -ten (10) unopened Lantus 100 units/ml insulin pens -six (6) unopened Humalog Kwik 100 units/ml insulin pens -one (1) unopened Ativan 2 mg vial The manufacturer's instructions for latanoprost dated September 16, 2015, directed to store unopened latanoprost solution in the refrigerator between 36-46 degrees F. Do not freeze. The manufacturer's instructions for naloxone dated August 28, 2020, directed to store naloxone between 68-77 degrees F. Temperature excursions were permitted between 41-104 F, (previously 59-104 F).	01880		

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01880	Continued From page 68 The manufacturer's instructions for hydrocodone dated August 2014, directed to store between 59-86 degrees. Dispense in a tight, light-resistant container with a child-resistant closure. The manufacturer's instructions for alprazolam dated June 8, 2020, directed to store at room temperature (77 degrees) away from light and moisture. Brief storage between 59-86 F is permitted. Do not store in the bathroom. The manufacturer's instructions for Clonazepam dated May 16, 2018, directed to store between 68-77 degrees. Protect from light. Store locked up. The manufacturer's instructions for lispro insulin dated December 5, 2022, directed to store unopened lispro in the refrigerator (36-46 F) until opened, do not freeze. The manufacturer's instructions for Lantus pen insulin dated March 2020, directed to store unopened Lantus in the refrigerator. The manufacturer's instructions for Humalog Kwik pen insulin dated April 2020, directed to store unopened Humalog in the refrigerator between 36-46 degrees F. The manufacturer's instructions for Ativan, dated June 8, 2022, directed to store unopened Ativan in the refrigerator between 36-46 degrees F. The licensee's Storage of Medications policy dated April 17, 2023, indicated the RN would provide education to the resident/resident' representative on proper storage of medications including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's	01880		

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01880	Continued From page 69 recommendations. This may include a combination of the resident's room and the nursing office; -when secured storage of the mediation was necessary, the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medication; -the RN would identify a process for monitoring or tracking a resident's controlled or their medications that might be at risk of diversion. The RN would establish a system that addressed the storage and handling of medication include: -how medications were received and secured when delivered by the pharmacy; -where medication were stored; -how medications would be secured if in the resident's private living space or if centrally stored; -who was authorized to access the medication. and Controls and procedures to identify or prevent diversion of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 70 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label for five of ten residents (R2, R7, R5, R8, R6). In addition, the licensee failed to date time-sensitive medications with an expiration date for two of two residents (R4, 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) 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: EXPIRED MEDICATIONS OVERFLOW CABINET On May 1, 2023, at 10:34 a.m., the surveyor reviewed the locked medication "overflow" cabinet with assistant director/unlicensed personnel (AD/ULP)-B confirming the following. R2 -R2's nystatin (yeast) powder had expired April 2023; -R2's Cal-gest (antacid) chews 500 milligram (mg) had expired February 2023; -R2's lubricating eye drops had expired February 21, 2023; -R2's Lasix 40 mg (diuretic) had expired July 27, 2022; and -R2's atorvastatin 80 mg (cholesterol) had expired July 27, 2022.	01890		

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01890	Continued From page 71 R7 -R7's acetaminophen/diphenhydramine (sleep aid) 500/25 mg had expired April 2023; and -R7's aspirin 81 mg (heart health) expired January 2020. R5 -R5's potassium (health supplement/helps nerves to function and muscles contract) 20 milliequivalents per liter (meq) last filled February 22, 2022, did not have an expiration date on the bottle; -R5's metformin (diabetes) 500 mg last filled January 21, 2022, did not have an expiration date on the bottle; -R5's Losartan (high blood pressure) 100 mg last filled August 2022, did not have an expiration date on the bottle; and -R5's Laxis (diuretic) 40 mg last filled January 28, 2022 did not have an expiration date on the bottle. On May 1, 2023, at 10:43 a.m., AD/ULP-B called the pharmacy used in regard to medications and the expiration dates. After speaking with the pharmacy AD/ULP-B stated the general rule was if more than one (1) year from the last fill, the medication was expired. MEDICATION REFRIGERATOR On May 1, 2023, at 10:47 a.m., the surveyor reviewed the locked medication refrigerator with AD/ULP-B confirming the following. R8 -R8's hydrocodone (pain) 325/5 mg had expired November 3, 2022; and -R8's alprazolam (anxiety/panic disorder).25 mg had expired on April 25, 2023.	01890		

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01890	Continued From page 72 MEDICATION CART On May 1, 2023, at 11:02 a.m., the surveyor reviewed the locked medication cart with AD/ULP-B confirming the following. R6 -R6's hydroxyzine (anxiety or allergic reaction) 25 mg had expired January 16, 2023. TIME SENSITIVE MEDICATIONS/ORIGINAL PRESCRIPTION LABEL On May 1, 2023, at 11:02 a.m., the surveyor reviewed the locked medication cart with AD/ULP-B confirming the following. -R4's opened Symbicort (relaxing the muscles around the airways) inhaler lacked the date the inhaler would expire; and R4's opened Incruse Ellipa (relaxing the muscles around the airways) 62.5 (microgram) mcg inhaler lacked the date the inhaler would expire. -R3's opened Trelegy Ellipa (chronic obstructive pulmonary disease) 100/62.5/25 mcg inhaler lacked the date the inhaler would expire; -R7's two (2) opened Advair (difficulty breathing, wheezing, shortness of breath) 250/50 mcg inhalers lacked the date the inhalers were opened and when the inhalers would expire. Directly following the above observation AD/ ULP-B stated she thought the expiration date on the medication boxes was the date the inhalers would expire. The manufacturer's instructions for Symbicort inhaler dated 2019, directed to discard three (3)	01890		

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01890	Continued From page 73 months after removal from foil pouch. The manufacturer's instructions for Incruse Ellipa inhaler dated February 2022, directed to throw away in the trash six (6) weeks after opening the tray or when the counter reads "0", whichever comes first. The manufacturer's instructions for Trelegy Ellipa inhaler dated 2022, directed to throw away the inhaler six (6) weeks after first removing it from the tray or when the dose counter reads zero, whichever comes first. The manufacturer's instructions for Advair inhaler dated 2019, directed to discard 30 days after removal from foil pouch. The licensee's Storage of Medications policy dated April 17, 2023, noted the RN would provide education to the resident/resident' representative on proper storage of medications including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office; -until the medications is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength, quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided.	01890		

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01890	Continued From page 74 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) to demonstrate the ability to follow the procedure to perform the tasks as required for one of one ULP (ULP-C). In addition, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R4, R5).	01950		

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01950	Continued From page 75 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: COMPETENCIES On May 2, 2023, at 6:56 a.m., ULP-C stated when hired an unidentified licensed practical nurse (LPN) taught her how to take/check vital signs, oxygen, ostomies, catheters, and check blood glucose. On May 2, 2023, at 8:25 a.m., the surveyor observed ULP-C clean R6's pointer finger of right hand, use a lancet (small device to prick skin). ULP-C massaged R6's finger encouraging blood flow. ULP-C wiped away the first drop of blood obtained and used the second drop of blood to obtain R6's blood glucose level. ULP-C's employee record contained a Nurse Observation Clearance for New Hires dated January 16, 2023, included: -glucometer operation; and -pulse/oximeter. This form was authenticated by unidentified LPN and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. ULP-C's employee record contained Protocols for (name of facility) dated January 16, 2023, which included:	01950		

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01950	Continued From page 76 -diabetic client care, initialed by unidentified LPN; and -oxygen therapy, "Educare" (on-line learning system). ULP's C employee record lacked documentation of competency evaluations for the following topics: -oxygen; -modified diets; -compression stockings (TEDs); -FreeStyle blood glucose monitoring system (measures glucose levels through a small sensor, applied to the back of an upper arm); and -finger prick blood glucose monitoring system (small needle used to poke the skin [usually on a finger] to get a small drop of blood and inserted into a meter.) On May 2, 2023, at 10:35 a.m., CNS-LALD-A stated TEDs, both types of blood glucose training and vital signs were taught by LPN. On May 3, 2023, at 10:16 a.m., CNS/LALD-A stated ULP-C received some of her training through Educare. CNS/LALD-A stated ULP-C's training was not completed by an RN. CNS/LALD-A added she was not working at the site at that time, she had taken a leave. CNS/LALD-A stated she trusted the unidentified LPN who did the training on "everything" (oxygen, blood glucose, TEDS, modified diets) for ULP-C. CNS/LALD-A stated she later signed the training form. The licensee's Training Licensed Personnel for Medication, Treatment and Therapy Administration policy dated April 17, 2023, noted before the RN delegated the task of assistance with self-administration of medication or the task	01950		

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01950	Continued From page 77 of medication administration, treatment and therapy the RN would instruct the ULP on performing these tasks and determine the ULP as competent to perform the tasks. The RN would document the training and competency of ULP to competently administer each type of service they are assigned in the staff's personnel record. SPECIFIC INSTRUCTIONS R4 R4's diagnosis included atrial fibrillation (irregular, rapid heart-rate), altered mental status, depression, and suprapubic urinary catheter (catheter inserted through abdomen directly into bladder.) R4's service plan dated September 14, 2022, noted to see care plan, for services provided. R4's care plan dated March 13, 2023, through March 31, 2023, included; - cleanse stoma (opening) area daily and prn (as needed or desired); and -empty catheter every shift and prn (use alcohol wipe per protocol). On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-G push R4's wheelchair into a bathroom and empty R4's catheter into the toilet. R4's after visit summary authenticated January 12, 2023, included: continue suprapubic catheter care. Clean insertion site daily with soap and water. Report to your doctor if you have signs of infection including redness, pain, pus and/or bad odor. Keep drainage bag below waistline and do not let catheter kink. R4's record did not contain specific instructions for R4's suprapubic catheter and insertion site.	01950		

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01950	Continued From page 78 On May 2, 2023, at 1:54 p.m., CNS/LALD-A stated R4's record did not contain specific instructions written out, adding it was in their (facility) protocols. R5 R5's diagnoses included diabetes. R5's service plan dated March 30, 2023, noted to see care plan, medication plan, and treatment plan for services provided. R5's treatment plan dated March 29, 2023, included: -glucometer checks three (3) times daily and prn, monitor and stabilize blood glucose levels on-going; and -ok to conduct in front of other residents. R5's April 1, 2023, through April 30, 2023, MAR included; -BG monitoring 3 times daily: 8:00 a.m., 12:00 p.m., and 5:00 p.m. R5's provider's orders dated November 29, 2022, included microlet lancet, 14-day FreeStyle Libre Sensor (sensor which continuously measures glucose levels worn in the back of an arm), and Freestyle Libre Reader. On May 2, 2023, at 7:16 a.m., the surveyor observed unlicensed personnel (ULP)-C hold a FreeStyle BG monitor up to R5's arm to check R5's blood glucose. R5's record did not include specified, in writing, specific instruction documented in the resident's record, to include when to report findings to nursing.	01950		

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01950	Continued From page 79 On May 2, 2023, at 1:38 p.m., CNS/LALD-A stated the facility has protocol they use. CNS/LALD-A said there were no specific written instructions in R5's record for BG monitoring. The licensee's Treatment and Therapy Management policy dated April 24, 2023, indicated the facility would use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. To include: -the RN would provide education to the client/responsible party regarding the treatment or therapy and may, as appropriate, instruct other team members, including paraprofessionals, to provide on-going teaching based on the written client education instructions prepared by the RN; -procedures for documenting treatments or therapies; and -procedures for notifying the RN when a problem arises related to the treatment or therapy service. -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; and No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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01960	Continued From page 80	01960		

include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for two of three residents (R3, R4).

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:

OXYGEN ADMINISTRATION
R3
R3's diagnosis included hypertension, asthma, kidney disease, and heart disease.

R3's service plan dated March 22, 2023, noted to see care plan, medication plan, and treatment plan for services provided.

R3's treatment plan dated January 20, 2023, included continuous oxygen therapy to increase resident breathing comfort, ongoing.

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01960	Continued From page 81 R3's provider's orders dated April 14, 2023, included continuous oxygen therapy. On May 2, 2023, at 7:30 a.m., the surveyor observed R3 seated at a table in the dining room wearing a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) attached to an operating oxygen concentrator. R3 requested assistance from unlicensed personnel (ULP)-C to use the bathroom. R3's nasal cannula was removed, and ULP-C assisted R3 into the restroom near the dining room. After using the restroom ULP-C assisted R3 back to the table where R3 had been sitting and the nasal cannula was reapplied. On May 2, 2023, at approximately 1:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R3's oxygen order was for continuous oxygen. CNS/LALD-A said she would get an order from hospice to change the oxygen order, adding even hospice does not follow the order for continuous oxygen. FLUID RESTRICTION R4 R4's diagnosis included atrial fibrillation (irregular, rapid heart-rate), altered mental status, depression, and suprapubic urinary catheter (catheter inserted through abdomen directly into bladder.) R4's service plan dated September 14, 2022, noted to see care plan, medication plan, and treatment plan for services provided. R4's care plan dated March 13, 2023, through March 31, 2023, included, 2000 milliliter (ml) fluid restriction.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28438	A. BUILDING: _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA SENIOR CARE LLC	540 EAST ISLE STREET ISLE, MN 56342

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01960	Continued From page 82 R4's discharge note from (name of hospital) authenticated by provider on January 12, 2023, included 8 cups (64 ounces =2000 ml) of fluid daily. R4's Nursing/Progress notes dated January 13, 2023, included R4 would be on fluid restrictions. On May 2, 2023, at 8:35 a.m., the surveyor observed ULP-G push R4's wheelchair into a bathroom and empty R4's catheter into the toilet. R4's record did not include documentation of R4's fluid intake. On May 2, 2023, at 1:49 p.m., CNS/LALD-A stated she was not working at the assisted living facility at that time the order was received. CNS/LALD-A stated her expectation would be to track input daily, to include the water bottles in R4's room. The licensee's Treatment and therapy Management plan dated April 24, 2023, indicated the registered nurse (RN) would prepare an individualized treatment or therapy management plan of each client receiving ordered or prescribed treatments or therapy services, which addressed: -type of service to be provided; -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; identification of treatment or therapy tasks delegated to unlicensed personnel, and -procedures for notifying the RN when a problem arises related to the treatment or therapy service;	01960		

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01960	Continued From page 83 In addition, when a treatment or therapy is not administered as ordered or prescribed, staff would document the reason why it was not administered any any follow-up procedures provided to meet the client's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	02140		

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02140	Continued From page 84 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 was licensed as an assisted living facility with dementia care. During the entrance conference on May 1, 2023, at approximately 9:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she oversaw the facility with assistance from AD/ULP-B (assistant director/unlicensed personnel.) CNS/LALD-A's employee record lacked evidence of successful completion of a competency or knowledge test required by the commissioner. On May 3, 2023, at 10:23 a.m., CNS/LALD-A and AD/ULP-B stated CNS/LALD-A had not completed the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02310 SS=F	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 85 This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for eight of eight oxygen tanks. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of hydrogen peroxide. 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: OXYGEN On May 1, 2023, at 11:20 a.m., during a tour of the facility with assisted living director/unlicensed personnel (AD/ULP)-B and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A the surveyor observed R3's door with an oxygen in use sign on the door. In R3's room an oxygen concentrator was on and there were eight oxygen tanks unsecured along a wall. Next to the eight unsecured oxygen tanks was an empty handheld oxygen cart. Directly following the above observation CNS/LALD-A stated the oxygen needed to be in a rack to secure the oxygen tanks. Minnesota Department of Health guidance,	02310		

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02310	Continued From page 86 Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. HYDROGEN PEROXIDE On May 1, 2023, at approximately 11:35 a.m., the surveyor inquired which bathroom/restroom should be used by visitors. CNS/LALD-A showed the surveyor a restroom near the dining room/common's area. CNS/LALD-A added staff, visitors, and residents may use "this" bathroom. On May 2, 2023, at 7:30 a.m., the surveyor observed ULP-C assist R3 into the restroom near the dining room. On May 2, 2023, at 8:24 a.m., the surveyor observed an opened bottle of hydrogen peroxide in the bathroom near the dining area. On May 2, 2023, at approximately 8:30 a.m., the surveyor observed R8 sitting at a table in the dining area and R8 asked staff if she could use the bathroom "out here", off the dining room. On May 2, 2023, at 9:42 a.m., CNS/LALD-A stated she was not aware a bottle of hydrogen peroxide was located in the restroom. CNS/LALD-A added the hydrogen peroxide should not be there, " it was definitely a hazard. Why would they have it in there?" On May 3, 2023, at approximately 10:15 a.m., CNS/LALD-A stated she removed the hydrogen peroxide from the restroom. Hazardous Substance Fact Sheet dated May 2016 indicated hydrogen peroxide noted is	02310		

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02310	Continued From page 87 unstable and an explosion risk. Hydrogen peroxide is on the Special Health Hazard Substance List. In addition, workplace controls and practices noted, "very toxic chemicals, or those that are reproductive hazards or sensitizers, required expert advice on control measures if a less toxic chemical cannot be substituted. Control measures include; (1) enclosing chemical processes for severely irritating and corrosive chemicals, (2) using local exhaust ventilation for chemicals that may be harmful with a single exposure, and (3) using general ventilation to control exposures to skin and eye irritants; -label process containers; -provide employees with hazard information and training; -monitor airborne chemical concentrations; -uses engineering controls if concentrations exceed recommended exposure levels; -provide eye wash fountains and emergency showers; -wash or shower if skin comes in contact with a hazardous material; -always wash at the end of the worksite; -change into clean clothing if clothing becomes contaminated; -do not take contaminated clothing home; -get special training to wash contaminated clothing; -do not eat, smoke, or drink in areas where chemical are being handled, processed or stored; and -wash hands carefully before eating, smoking, drinking, applying cosmetics or using the toilet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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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 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 privacy was maintained for two of two residents (R5, R6) while receiving services. 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	02410		

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02410	Continued From page 89 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5 R5's diagnoses included diabetes. R5's service plan dated March 30, 2023, noted to see care plan, medication plan, and treatment plan for services provided. R5's treatment plan dated March 29, 2023, included glucometer checks three times daily and as needed, ok to conduct in front of other residents. On May 2, 2023, at 7:16 a.m., the surveyor observed R5 sitting at a table in the open dining area, two other residents of the facility were also seated in the dining area at this time. The surveyor observed unlicensed personnel (ULP)-C hold a FreeStyle (sensor which continuously measures glucose levels worn in the back of an arm) blood glucose monitor up to R5's arm to check R5's BG. ULP-C then cleaned an area of R5's upper right arm with an alcohol pad and administered 6 units of Lispro (fast acting insulin) and 28 units of Lantus (long-acting insulin) while R5 was seated in the dining area. At no time during the observation did the surveyor observe ULP-C ask R5 if he wanted to go to his room or ask the two residents in the dining area if they had any concerns with R5's blood glucose monitoring or insulin administration. R5's Minnesota Bill of Rights for Assisted Living Residents authenticated March 23, 2022, noted	02410		

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02410	Continued From page 90	02410		

residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Residents have the right to engage in community life and in activities of their choice. This included the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.

R6
R6's diagnoses included diabetes.

R6's service plan dated March 13, 2023, noted to see care plan, medication plan, and treatment plan for services provided.

R6's treatment plan dated March 13, 2023, included glucometer checks three times daily and as needed, ok to conduct in front of other residents.

On May 2, 2023, at 8:25 a.m., the surveyor observed R6 sitting in the open dining area with her breakfast in front of her, and one other resident of the facility was seated in the dining area at this time. The surveyor observed ULP-C clean R6's pointer finger of right hand, use a lancet (small device to prick skin). ULP-C massaged R6's finger encouraging blood flow. ULP-C wiped away the first drop of blood obtained and used the second drop of blood to obtain R6's blood glucose level. At no time during the observation did the surveyor observe ULP-C ask R6 if she wanted to go to her room or ask the resident in the dining area if they had any concerns with R6's blood glucose monitoring.

R6's Minnesota Home Care Bill of Rights for

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02410	Continued From page 91 Assisted Living Clients of Licensed Only Home Care authenticated November 26, 2019, noted care and services according to a suitable and up-to date plan, and subject to accepted health care, medical or nursing standards and person-centered care. In addition, be served by people who are properly trained and competent to perform their duties. On May 2, 2023, at approximately 10:15 a.m., clinical nurse supervisor/assisted living director (CNS/LALD)-A stated both R5's treatment plan and R6's treatment plan dated March 29, 23, and March 13, 23, respectively noted "ok, to conduct in front of other residents". CNS/LALD-A added ULPs were to ask other residents in the area if they were ok with blood glucose monitoring. CNS/LALD-A said ULP-C should have asked other residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *05/01/23*
Time: 12:15:00
Report: 1017231099

Food and Beverage Establishment Inspection Report

Location:
Scandia Senior Care Llc
540 East Isle Street
Isle, MN56342
Mille Lacs County, 48

Establishment Info:
ID #: 0038317
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202663028
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

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

DISH MACHINE MEASURED 150 DEGREES F. MAINTAIN DISH MACHINE AT 160 MINIMUM TEMPERATURE.

Comply By: 05/01/23

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: BRATWURST SUPPER STOVE TOP
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: PEPPERJACK CHEESE UPRIGHT COOLER
Violation Issued: No

Type: Full
Date: *05/01/23*
Time: 12:15:00
Report: 1017231099
Scandia Senior Care Llc

Food and Beverage Establishment Inspection Report

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

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 1017231099 of 05/01/23.

Certified Food Protection Manager: MORGAN M BRANDT

Certification Number: FM 106125 Expires: 04/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231099

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	**Date**	05/01/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:15:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Scandia Senior Care Llc	540 East Isle Street	Isle, MN	56342	3202663028

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0038317		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/02/23

Inspector (Signature)