Electronically delivered

January 28, 2022

Administrator
Savanna Prairie
260 Magnus Johnson Street Northeast
Kimball, MN 55353

RE: Project Number(s) SL35045015

Dear Administrator:

On January 10, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 28, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 28, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 28, 2021, found not corrected at the time of the January 10, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 10, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jeri Cummins at 218-302-6193.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jeri Cummins, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-302-6193 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35045	A. BUILDING: _____ B. WING _____	R 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 1144.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL35045015 On January 10, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 28, 2021. At the time of the survey, there were 27 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, 0970 was reissued. The other orders were corrected.	{0 000}	Assisted Living Provider 144G. 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.	

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{0 780}	Continued From page 1	{0 780}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	{0 810}		

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{0 810}	Continued From page 2 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: No further action required.	{0 810}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	{0 970}		

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{0 970}	Continued From page 3 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 10, 2022, at approximately 12:30 p.m., a copy of the facility's assisted living contract was requested. Licensed assisted living director (LALD)-A confirmed the assisted living contract had not been revised and contained the same language as when reviewed on October 27, 2021, which required residents to waive the facility's liability for health, safety, or personal property. LALD-A confirmed the same assisted living contract was used for all residents at the facility. The assisted living contract included two clauses that indicated the resident would waive the	{0 970}		

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{0 970}	Continued From page 4 facility's liability for health, safety, or personal property of a resident. Page 15, section 2. of the contract indicated a resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. Page 15-16, section 4. of the contract indicated the provider was not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. The licensee's Contract policy dated August 1, 2021, indicated the assisted living contract would contain, but was not limited to, the following element: Waivers of liability prohibited. The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. No further information was provided.	{0 970}		

Electronically Delivered

November 18, 2021

Administrator
Savanna Prairie
260 Magnus Johnson Street NE
Kimball, MN 55353

RE: Project Number(s) SL35045001

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 28, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

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

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

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

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

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement = $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jeri Cummins, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-302-6193 Fax: 651-215-9697

PMB

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	35045	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #SL35045015 On, October 26, 2021, through October 28, 2021, 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 33 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A 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.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	0 115		

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0 115	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance with having a secured unit. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility. During the entrance conference on October 26, 2021, at approximately 12:40 p.m. licensed assisted living director (LALD)-A confirmed the	0 115		

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0 115	Continued From page 2	0 115		

facility was considered secure with key pad access at each entry.

During the facility tour on October 26, 2021, at approximately 1:00 p.m. registered nurse (RN)-B confirmed only "some" of the residents residing on the south unit were provided the access code for the main entrance; no residents residing on the north unit were provided the access code. Signage posted on the north/south entrance door noted "Make sure I'm closed" and a sign posted on the window adjacent to the north/south entrance noted "Stop [stop sign with hand printed inside of the stop sign] keep door closed to protect our residents."

On October 26, 2021, at approximately 1:45 p.m. during the tour of the north unit, RN-B confirmed the north unit had a current census of 15 residents, and the south unit had a census of 18 residents. RN-B confirmed the north unit had "more dementia and confused" residents and four of the 15 residents wandered. RN-B confirmed the north unit had four key pad secured exits, and the south unit had three key pad secured exits.

R10
R10's diagnoses included, but were not limited to, dementia, at-risk for unsafe behavior, tendency to wander, and type 2 diabetes mellitus.

R10's Master Care Plan last updated on August 4, 2021, indicated R10's evacuation acuity to be a level 2. R10 required staff observation at all times related to dementia and would easily walk away during an emergency. R10 was assessed as not able to demonstrate ability to call for help in emergencies or activate emergency call system due to dementia. The Master Care Plan further indicated R10 was at risk for elopement and

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0 115	Continued From page 3 wandering. On October 26, 2021, at 2:45 p.m., R10 was observed to be wandering in the common area. On October 26, 2021, at 3:00 p.m., R10 was observed to exit seek and attempted to open the key pad secured exit door from the north to the south unit. On October 26, 2021, at 3:20 p.m., R10 was observed to exit seek at the key pad secured exit door from the north to the south unit. On October 26, 2021, at 3:35 p.m., R10 was observed to be exit seeking at the key pad secured exit from the north to south unit and was redirected back to her room by ULP-E. On October 26, 2021, at 3:45 p.m., R10 was observed to be wandering in and out of other resident rooms. R11 R11's diagnoses included, but were not limited to, delusional disorder and major neurocognitive disorder. R11's Master Care Plan last updated October 1, 2021, indicated R11's evacuation acuity to be a level 2. R11 was ambulatory and required moderate care and required assistance in evacuation and supervision 24/7 due to dementia. R11 was assessed as unable to demonstrate ability to activate a facility wide call system. On October 26, 2021, at 3:20 p.m., R11 was observed to be standing at the main exit of the north unit.	0 115		

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0 115	Continued From page 4 On October 26, 2021, at 3:45 p.m., R11 was observed to be standing by the door to the main exit of the north unit. On October 27, 2021, at 9:22 a.m., an interview with the owner, licensed assisted living director (LALD)-A, RN-B and RN-C was conducted. The owner stated the decision for the application of the assisted living license was based off of the facility's previous license. The owner confirmed the current advertisement on the facility's website included information regarding having 24 hour awake staff and that the building was secured for the safety of all residents. LALD-A confirmed the north unit was a secure unit, and the owner went on to confirm both the north and south units were secured. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 115		
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;	0 680		

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0 680	Continued From page 5 and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. The licensee failed to maintain testing and maintenance records for the emergency generator. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: EPP On October 26, 2021, at approximately 1:00 p.m., a request was made to view the licensee's EPP. The plan included a Hazard and Vulnerability	0 680		

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0 680	Continued From page 6 Assessment Tool and policies and procedures related to natural and man-made disasters, as well as generic provisions on how staff should respond in various situations; however, the facility's plan lacked the following required content: -an assessment of the at risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EPS officials/organizations; -procedure for tracking residents and staff; -an evacuation plan to include staff responsibilities during an evacuation; -a plan for how the facility would provide a means to shelter in place for residents, staff and volunteers; and -development of emergency staffing strategies to include volunteers. The EPS communication plan lacked the following required content: -contact information for federal, state, regional EPS staff, state licensing and certification agency and Office of the State Long Term Care Ombudsman; -primary and alternative means of communicating with facility staff, federal, state, tribal, regional and local emergency management agencies; -a means of providing information about the facilities needs and its ability to provide assistance to include information about their occupancy; and -a method for sharing information from the emergency plan with residents and their families. On October 27, 2021, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed she believed the facility had all required components of the EPP developed; however, during further discussion, LALD-A	0 680		

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0 680	Continued From page 7 agreed some areas could be more developed. On October 28, 2021, at 8:30 a.m., additional policies and procedures were provided. The additional information did not include all the required content as outlined above. GENERATOR The facility failed to provide the required testing and inspection record keeping information for review of the standby emergency generator as part of the EPP (shelter-in-place) to ensure proper performance during a power outage: -records of the required emergency generator monthly load test in accordance with NFPA 110; and -records of the required weekly emergency generator maintenance and inspections as outlined under NFPA 110. On October 27, 2021, at approximately 3:00 p.m., the findings were verified with the director of maintenance, (DM)-K as he clarified the emergency generator served the facility emergency lights in the south building and all systems of the north building. DM-K stated the generator system was set to auto test every Monday, but no records were provided for review. The licensee's Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated the facility EPP would include all required elements of Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 8	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a smoke alarm was maintained in a resident room. This had the potential to affect the safety of all residents and staff for early smoke and/or fire detection. 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	0 780		

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0 780	Continued From page 9 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 27, 2021, at approximately 1:00 p.m. during observation, the smoke alarm in bedroom #138 did not alarm when tested by the maintenance staff (MS)-L. This was verified by both director of maintenance (DM)-K and MS-L as he stated that the batteries just need to be replaced. On October 27, 2021, at 3:55 p.m., the licensed assisted living director (LALD)-A and DM-K verified the finding during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 10 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 interview, observation, and record review, the licensee did not have the required documentation on fire safety and evacuation plans. The licensee did not provide the required records of staff and resident training on fire and safety evacuation. This has the potential to directly affect the safety of all residents, visitors, 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).	0 810		

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0 810	Continued From page 11 The findings include: On October 27, 2021, at approximately 12:30 p.m., survey staff were introduced to the director of maintenance (DM)-K and maintenance staff (MS)-L. The survey staff requested the facility fire safety and evacuation plan documentation, including records of evacuation drills and training records for review. The DM-K indicated that the documents were in electronic format and could be obtained. At 12:40 p.m., staff were only provided with copies of the posted (near the entrance) emergency evacuation fire safety plan. At approximately 3:20 p.m., toward the end of the facility tour, staff again asked DM-K for the required complete documentation and training records for review to complete the survey; only the evacuation drills were provided for review. At 3:55 p.m., the remaining requested documentation and training records were still not available for review during the survey. The facility posted evacuation fire safety and emergency building layout plans for the north and south buildings, but both were incomplete and did not include the details of evacuation routes for fire safety and emergencies. The building layout plan of each building did not include room identifiers and was not legible. Evacuation and fire safety plan and documentation were not readily available, and did not address specific procedures for employee fire protection procedures necessary for the residents, including procedures for their movements, relocation during a fire or similar, and must consist of written instructions for addressing any unique resident situation during evacuation, especially for residents who are	0 810		

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0 810	Continued From page 12 wheelchair bound and needing assistance during evacuation. No required records or specific schedule on training of employees on fire safety and evacuation were provided. No required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation were provided. On October 27, 2021, at approximately 3:55 p.m., DM-K and licensed assisted living director (LALD)-A verified the findings during the exit interview as they stated they will still need to access the requested documents and records electronically and agreed to email to surveyors by the end of the day. Additional information was provided via email on fire safety documentation and training schedule on October 28, 2021, at 8:44 a.m., but did not include all the required content as outlined above. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 26, 2021, at approximately 1:00 p.m., a copy of the facility's assisted living contract was requested. The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 2. of the contract indicated a resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. Page 15-16, section 4. of the contract indicated the provider was not	0 970		

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0 970	Continued From page 14 liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On October 27, 2021, licensed assisted living director (LALD)-A confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property. LALD-A confirmed the same assisted living contract was used for all residents at the facility. A policy on content of assisted living contracts was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 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 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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01370	Continued From page 15 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed in all required areas for one of one unlicensed personnel (ULP)-D with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01370		

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01370	Continued From page 16 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on September 1, 2021, to provide direct care services to residents of the facility. On October 26, 2021, at approximately 4:00 p.m., ULP-D was observed conducting a blood glucose check and administering insulin to R1. ULP-D's employee record lacked evidence to indicate ULP-D completed training for maintenance of a clean and safe environment. On October 27, 2021, at approximately 3:35 p.m., licensed assisted living director (LALD)-A confirmed ULP-D had not completed the required training noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted a copy of all education, training, and competency testing would be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01420 SS=F	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	01420		

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01420	Continued From page 17 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 an 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 one unlicensed personnel (ULP)-H who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-F was hired on August 1, 2021, to provide direct care services to residents of the facility. On October 26, 2021, from 2:45 to 3:45 p.m., R4 was observed to be in his wheelchair in the commons area with a lap buddy (a padded	01420		

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01420	Continued From page 18 cushion, resting across resident's lap, frequently used as a tray, positioning device and/or restraint) across his lap, strapped to the wheelchair arms with Velcro straps. On October 27, 2021, at 9:50 a.m., R4 was observed to be asleep in his bed with a bed alarm in place. ULP-H confirmed R4 was to have the bed alarm in place when in bed to alert staff he was attempting to sit up. ULP-H confirmed R4 used a lap-buddy when in his wheelchair as a tray. ULP-H stated she often would place R4's lap buddy in the wheelchair and bed alarm on the bed. ULP-H's employee record lacked documentation to indicated ULP-H had received training and demonstrated competency in the use of a lap buddy and bed alarm. On October 27, 2021, at 3:40 p.m., RN-B confirmed ULP-H nor any other direct care staff were trained and demonstrated competency in the use of a lap buddy or bed alarm. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated the RN would determine what nursing services may be delegated to properly trained and competency tested ULPs, and a copy of all education, training, and competency testing shall be kept in each employee's personnel file. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		

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01770	Continued From page 19	01770		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document all required content for medication setup for one of one resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on October 26, 2021, at approximately 12:30 p.m., licensed assisted living director (LALD)-A, registered nurse (RN)-B and RN-C confirmed the licensee provided medication management services. R3's diagnoses included, but were not limited to, diabetes, chronic kidney disease, depression, and hypertension (high blood pressure). R3's service plan and individualized medication management plan dated September 10, 2021, indicated R3 received medication management	01770		

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01770	Continued From page 20 services. R3's prescriber orders dated October 13, 2021, included an order for hydrocodone/acetaminophen 5/325 milligrams (mg) (Hydro-APAP- a narcotic to treat severe pain) two tablets orally three times a day and continue as needed as ordered. On October 26, 2021, at approximately 1:20 p.m., the south medication cart was reviewed with RN-B and RN-C. Observed in the double locked narcotic box were two small clear baggies labeled with R3's name "Hydro-APA 5/325 mg Take 2 tabs by mouth daily as needed." Each baggie contained two pills. RN-B confirmed she and RN-C had set up these medications and made a note in R3's electronic record. A review of R3's record lacked documentation by the licensed nurse at the time of medication setup to include documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup. RN-B and RN-C confirmed R3's medication setup for R3's hydrocodone/acetaminophen was not documented in R3's record to include the required content noted above. The licensee's Medication Management - Dosage Box Setup policy dated August 1, 2021, indicated a licensed nurse at the facility would setup resident dosage boxes timely and accurately with documentation to include: dates of medication setup; medication name; quantity of dose; times to be administered; route of administration; name of the person completing the medication setup; visual description of medication; and drug classification and special precautions.	01770		

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01770	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two medication refrigerators (south) maintained an acceptable temperature to ensure medications were stored according to manufacturer's recommendations. 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: On October 26, 2021, at approximately 1:00 p.m., the south medication refrigerator located in the locked medication room was observed with registered nurse (RN)-B. RN-B confirmed the	01880		

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01880	Continued From page 22 current temperature of the refrigerator was 38 degrees Fahrenheit (F). RN-B stated the temperatures were monitored daily and recorded in their electronic record. The refrigerator contained the following medications: - four (4) unopened Novolog 100 units/milliliters (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for resident (R)7 - three (3) unopened Basaglar 100 units/ml insulin pens for R7 - five (5) unopened Lantus 100 units/ml insulin pens for R1 - three (3) Humalog 100 units/ml insulin pens for R1 - six (6) Lantus 100 units/ml insulin pens for R12 - three (3) Trulicity 1.5 milligrams/0.5 ml pens for R12 - five (5) Lantus 100 units/ml insulin pens for R8 On October 26, 2021, at approximately 2:45 p.m., RN-C provided the south medication refrigerator temperature log dated September 26, 2021, through October 25, 2021. The south medication refrigerator temperature had been monitored daily (30 times); 16 of the 30 times the refrigerator temperature was recorded as below 36 degrees F. RN-C confirmed the above noted temperature readings were not in the acceptable range. The manufacturer's instructions for Novolog insulin pens dated November 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Basaglar insulin pens dated December 2015, indicated unopened pens should be stored in the refrigerator at 36 to 46 degrees F.	01880		

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01880	Continued From page 23 The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not allow to freeze. The manufacturer's instructions for Humalog insulin pens dated April 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Trulicity pens dated September 2020, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The licensee's Safety-Refrigerator Temperature Monitoring policy (undated) noted medication refrigerator temperatures would be monitored and recorded daily. Refrigerator temperatures for medications, would be maintained between 36-46 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 24 by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained, including the expiration date for time sensitive medications, for three of three residents (R2, R6 and R9) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On October 26, 2021, at approximately 1:05 p.m., the locked south medication carts were reviewed with registered nurse (RN)-C. The following was observed and confirmed by RN-C: R2's activated Incruse Ellipta (inhaler that works by relaxing muscles in the airways to improve breathing) 62 micrograms (mcg) lacked a label which indicated the date the inhaler was removed from the pouch and when the inhaler would expire. R2's activated Breo Ellipta (corticosteroid inhaler) 200/25 lacked a label which indicated the date the inhaler was removed from the pouch and when the inhaler would expire. R2's Latanoprost ophthalmic 125 mcg/2 milliliters (glaucoma medication) lacked a label which indicated the date the eye drop solution was opened and when it would expire.	01890		

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01890	Continued From page 25 R6's activated Breo Ellipta 200/25 inhaler lacked a label which indicated the date the inhaler was removed from the pouch and when the inhaler would expire. R9's activated Incruse Ellipta inhaler 62.5 mcg and Breo 100/25 inhaler lacked a label which indicated the date the inhalers were removed from their pouches and when the inhalers would expire. On October 26, 2021, at approximately 1:15 p.m., RN-C stated she was unaware inhalers needed to be dated when removed from their pouches and when they would expire. The manufacturer's instructions for the use of the Incruse Ellipta inhaler dated February 2016 directed for the inhaler to be discarded six weeks after it is opened from the foil tray. The date opened should be written on the label of the inhaler. The manufacturer's instructions for the use of the Breo Ellipta inhaler dated May 2017 directed for the inhaler to be discarded six weeks after it is opened from the foil tray. The tray opened and discard dates should be written on the inhaler label. The manufacturer's instructions for use of Latanoprost ophthalmic solutions, revised February 2018, directed for the eye drop solution to be discarded six weeks after it is opened. The licensee's Medication Storage policy dated August 1, 2021, noted a prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information	01890		

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01890	Continued From page 26 including the expiration or beyond-use date of a time sensitive dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 27 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R4) receiving modified diets with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on October 26, 2021, at approximately 12:45 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R4's record lacked evidence of a written statement on R4's service plan and development of an individualized treatment plan to include puree diet and thickened liquids. R4's individualized treatment and therapy plan dated August 27, 2021, lacked the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions	01940		

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01940	Continued From page 28 relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received. R4's diagnoses included but were not limited to, cerebral infarction (stroke), vascular dementia, pain, movement disorder, and dysphagia (difficulty swallowing). R4's Master Care Plan dated September 20, 2021, indicated R4 received a pureed diet. R4's prescriber orders dated October 13, 2021, included an order for Boost Supplement twice daily, use ThickIt to thicken to nectar consistency, as well as an order for pureed diet. R4's Medication Administration Summary from October 1, 2021, through October 27, 2021, directed Boost Supplement twice daily, use ThickIt to thicken to nectar which was documented as completed twice daily. R4's Services Delivered documentation from September 27, 2021, through October 27, 2021, directed staff to record the percentage of the meal; however, the documenation did not confirm the meal texture. On October 27, 2021, at 3:30 p.m., RN-B confirmed R4's treatment plan lacked the above required content.	01940		

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01940	Continued From page 29 The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the facility would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -A statement of the type of services that will be provided; -Documentation of specific resident instructions relating to the treatments or therapy administration; -Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -Any resident-specific requirements relating to documentation of treatment and therapy received; -Verification that all treatment or therapy was administered as prescribed; and -Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	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 include the date and time of administration. When treatment or therapies are not administered as	01960		

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01960	Continued From page 30 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 treatment or therapies were administered as directed and failed to document the reason they were not administered and any follow up procedures provided to meet the resident's needs for one of one resident (R1) with blood glucose (sugar) monitoring managed by the provider with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee failed to ensure the registered nurse (RN) was notified of R1's high blood glucose levels as ordered. R1's diagnoses included, but were not limited to, diabetes, anxiety, bipolar (a mental health condition that causes extreme mood swings that include emotional highs and lows), and hypertension (high blood pressure). R1's service plan dated October 7, 2021, indicated R1 received blood glucose monitoring	01960		

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01960	Continued From page 31 four times a day. R1's prescriber orders dated October 18, 2021, included an order for blood glucose monitoring to be completed as needed and for Humalog insulin to be administered per the following sliding scale before meals: BS (blood sugar) greater than 400 = give 16 units of Humalog and update RN to update NP (nurse practitioner) BS 351- 400 = give 12 units of Humalog BS 301- 350 = give 10 units of Humalog BS 251- 300 = give 8 units of Humalog BS 201 - 250 = give 6 units of Humalog If blood sugar is less than 70, notify nurse. On October 26, 2021, at approximately 4:00 p.m., unlicensed personnel (ULP)-D was observed using appropriate technique to conduct a blood glucose check for R1 which resulted in a reading of 227 milligrams (mg)/deciliter (dL). After reviewing R1's electronic medication administration record (MAR), ULP-D stated R1would receive a total of 16 units of Humalog insulin as R1 had 10 units scheduled at this time and would receive an additional 6 units based off R1's sliding scale (a scale which directs how much insulin should be given based off the blood glucose results). R1's Service Recap - Blood Glucose report dated September 27, 2021, through October 26, 2021, indicated blood glucose levels were completed four times a day. The following dates resulted in a blood glucose level over 400: - October 3, 2021, at 8:05 p.m. with a BS result of 514 mg/dL - October 16, 2021, at 4:02 p.m., with a BS result of 411 mg/dL - October 17, at 3:31 p.m., with a BS result of 450	01960		

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SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

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01960	Continued From page 32 mg/dL R1's record lacked evidence the RN was notified of these three above noted blood glucose results, which was greater than 400 mg/dL as ordered by the prescriber. On October 27, 2021, at approximately 3:20 p.m., licensed assisted living director (LALD)-A confirmed there was no evidence of documentation an RN was notified of R1's elevated blood glucose results noted above as directed by the prescriber. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated for each treatment and/or therapy provided and documentation, including the date, time and administration would be documented in the resident's record. If the treatment and/or therapy was not completed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35045	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 33 section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure the facility was staffed twenty four hours a day, seven days a week in the two key pad secured units (north and south). This had the potential to affect all residents residing at the facility and resulted in an immediate correction order on October 27, 2021, at 1:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: The facility was licensed as an assisted living facility. During the entrance conference on October 26, 2021, at approximately 12:40 p.m. licensed assisted living director (LALD)-A confirmed the facility's staffing schedule included two awake overnight unlicensed personnel (ULP); one ULP scheduled for the north unit and one scheduled for the south unit. During the facility tour on October 26, 2021, at approximately 1:00 p.m. registered nurse (RN)-B confirmed only "some" of the residents residing on the south unit were provided the access code for the main entrance; and no residents residing on the north unit were provided the access code. Signage posted on the north/south entrance door noted "Make sure I'm closed" and a sign posted	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35045	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 34	02070		

on the window adjacent to the north/south entrance noted "Stop [stop sign with hand printed inside of the stop sign] keep door closed to protect our residents".
On October 26, 2021, at approximately 1:45 p.m. during the tour of the north unit RN-B confirmed the north unit had a current census of 15 residents and the south unit had a census of 18 residents. RN-B confirmed the north unit had "more dementia and confused" residents, and four of the 15 residents wandered. RN-B confirmed the north unit had four key pad secured exits and the south unit had three key pad secured exits.
R10
R10's diagnoses included, but were not limited to dementia, at risk for unsafe behavior, tendency to wander, and type 2 diabetes mellitus.
R10's Master Care Plan last updated on August 4, 2021, indicated R10's evacuation acuity to be a level 2, resident required staff observation at all times related to dementia and would easily walk away during an emergency. In addition, R10 was assessed as not able to demonstrate ability to call for help in emergencies or activate emergency call system due to dementia. The Master Care Plan further indicated R10 was at risk for elopement and wandering.
On October 26, 2021, at 2:45 p.m. R10 was observed to be wandering in the common area.
On October 26, 2021, at 3:00 p.m. R10 was observed to exit seek and attempted to open the key pad secured exit door from the north to the south unit.
On October 26, 2021, at 3:20 p.m. R10 was observed to exit seek at the key pad secured exit door from the north to the south unit.
On October 26, 2021, at 3:35 p.m. R10 was observed to be exit seeking at the key pad secured exit from the north to south unit and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35045	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 35	02070		

redirected back to her room by ULP-E.
On October 26, 2021, at 3:45 p.m. R10 was observed to be wandering in and out of other resident's rooms.
R11
R11's diagnoses included, but were not limited to delusional disorder and major neurocognitive disorder.
R11's Master Care Plan last updated October 1, 2021, indicated R11's evacuation acuity to be a level 2, resident was ambulatory and required moderate care and required assistance in evacuation and supervision 24/7 due to dementia. In addition, R11 was assessed as unable to demonstrate ability to activate a facility wide call system.
On October 26, 2021, at 3:20 p.m. R11 was observed to be standing at the main exit of the north unit.
On October 26, 2021, at 3:45 p.m. R11 was observed to be standing by the door to the main exit of the north unit.

STAFFING OVERNIGHT
On October 27, 2021, at 5:53 a.m. ULP-G stated she was the only ULP who worked the overnight in the south unit. ULP-G stated she went over to the north unit twice last night and the ULP that was assigned the north unit came over once and assisted her with a resident.
On October 27, 2021, at 6:00 a.m. ULP-F stated she was the only ULP who worked the overnight in the north unit. ULP-F stated she had left the unit one time during the night to assist on the south unit. ULP-F stated she was gone from the north unit for approximately 10 minutes; however, ULP-F stated she had worked nights where she had been on the south unit for up to 30 minutes and/or had to leave the north unit multiple times to assist on the south unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35045	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNA PRAIRIE	260 MAGNUS JOHNSON STREET NE KIMBALL, MN 55353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02070	Continued From page 36 On October 27, 2021, at 9:22 a.m. an interview with the owner, LALD-A, RN-B and RN-C was conducted. The owner stated the decision for the application of the assisted living license was based off of the facility's previous license. The owner confirmed the current advertisement on the facilities website included information regarding having 24 hour awake staff and that the building was secured for the safety of all residents. LALD-A confirmed the north unit was a secure unit and the owner went on to confirm both the north and south units were secure. LALD-A confirmed the overnight staff do go back and forth from the north and south unit to assist each other when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On October 27, 2021, at approximately 3:30 p.m. a plan for correction was received from the facility, and observations and interviews determined the immediacy could be removed on October 28, 2021, at approximately 12:00 a.m.	02070		

Minnesota Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/26/21*
Time: 13:26:49
Report: 7978211170

Food and Beverage Establishment Inspection Report

Location:
Savanna Prairie
260 Magnus Johnson Street Ne
Kimball, MN55353
Stearns County, 73

Establishment Info:
ID #: 0037692
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203988643
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE AT DISH LEVEL
Violation Issued: No

Chlorine: = 200 at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: CARROTS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 168 Degrees Fahrenheit - Location: GRAVY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: BAKED POTATOES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: CUT LETTUCE
Violation Issued: No

Type: Full
Date: *10/26/21*
Time: 13:26:49
Report: 7978211170
Savanna Prairie

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: TURKEY SANDWICH
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7978211170 of 10/26/21.

Certified Food Protection Manager: LORI WOOLARD

Certification Number: 52824 Expires: 06/26/22

Signed: _____
Establishment Representative

Signed: _____
Inspector ID #7978

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

Report #: 7978211170

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	10/26/21
No. of Repeat RF/PHI Categories Out	0	Time In	13:26:49
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Savanna Prairie	260 Magnus Johnson Street Ne	Kimball, MN	55353	3203988643

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037692		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 10/26/21

Inspector (Signature)