Electronically Delivered

February 22, 2023

Licensee
Bridgewell Assisted Living
410 West Main Street
Osakis, MN 56360

RE: Project Number(s) SL25904015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 20, 2023, 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.

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

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 evaluation of your facility**.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for

reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please email 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25904	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25904015-0 On January 17, 2023, through January 20, 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 16 active residents; all of whom received services under the provider's 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee lacked a system for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week for two of two residents (R1 and R2). This had the potential to affect all 16 residents 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 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:	0 460		

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0 460	Continued From page 2 The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022, and was licensed for a bed capacity of 20 residents. During the entrance conference on January 17, 2023, at 10:10 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated the facility did not have a call system in place for residents to request assistance when needed, since they were a dementia unit. LALD-D stated the staff made frequent checks on residents or the residents came to staff if they needed assistance. During the initial tour of the facility with CNS-A on January 17, 2023, from 10:55 a.m. through approximately 11:20 a.m., the evaluator observed the facility consisted of a large area divided into two sections, the north and south side. Residents were free to move about on either side. Each section had a dining room, living room, kitchenette, day room, and a hallway with seven rooms. CNS-A stated rooms 1, 3 and 7 on each side had the capacity for two residents, and the others were single rooms. The facility was accessed with a badge. The current census at the facility was 16 residents, with one currently in the hospital. R1 R1's diagnoses included dementia. R1 resided in a secured unit on the south section. On January 18, 2023, at 1:50 p.m., the evaluator observed R1 in her bed. R1 did open her eyes and look at the evaluator, but did not respond verbally when spoken to or when asked how she would call for help.	0 460		

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0 460	Continued From page 3 R2 R2's diagnoses included dementia and schizophrenia. R2 resided in a secured unit on the south section. On January 17, 2023, at 2:55 p.m., the evaluator observed R2 in the hallway by the main entrance to the unit, seated in a chair. R2 stated she was looking for her daughter. R2 was unable to say how she would call for help if she needed to. On January 17, 2023, at 11:55 a.m., LALD-D stated there was no means for residents to summon for staff, and added the building was built before she started working there. On January 18, 2023, at 10:45 a.m., LALD-D stated she ordered 50 bells to put in place for the residents to use to summon help. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 4 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	0 550		

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0 550	Continued From page 5 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee failed to post information including the telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. During the facility tour on January 17, 2023, at 10:10 a.m., the evaluators observed the entry area, common areas, and dining areas within the facility with clinical nurse supervisor (CNS)-A, and noted the grievance procedure was posted inside	0 550		

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0 550	Continued From page 6 the main entryway near the staff office. The licensee's Concerns and Grievance Procedure dated July 26, 2021, listed the name and titles of the individuals to contact with a grievance internally. However, it lacked the telephone number and e-mail contact information. On January 17, 2023, at 2:00 p.m., licensed assisted living director (LALD)-B stated the procedure lacked the required contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the	0 630		

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0 630	Continued From page 7 required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked an individual abuse prevention plan to include an assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. R2's Assessment for client vulnerability, safety, and risks to others dated March 1, 2022, noted areas of vulnerability and the potential risk to other vulnerable adults or staff. However, the assessment lacked the resident's susceptibility to abuse as required. On January 19, 2023, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated a new form with the required content had been implemented. However, the new form was not completed for R2.	0 630		

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0 630	Continued From page 8 The licensee's Individual Abuse Prevention Plans policy dated reviewed on August 1, 2022, noted an individual abuse prevention plan would be developed for each assisted living resident, and would include an individualized review or assessment of the resident's susceptibility to be abuse by another individual, including other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all current residents,	0 640		

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0 640	Continued From page 9 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 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 licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the facility tour on January 17, 2023, at 10:10 a.m., the evaluators observed the entry area, common areas, and dining areas within the facility with clinical nurse supervisor (CNS)-A, and noted there was no required posting of the 911 emergency number, as required. On January 17, 2023, at 2:00 p.m., licensed assisted living director (LALD)-B stated the 911 emergency information was not posted, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 10 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to prominently post a written emergency preparedness plan (EPP). This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	0 680		

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0 680	Continued From page 11 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on January 17, 2023, at 10:10 a.m., the evaluators observed the entry area, common areas, and dining areas within the facility with clinical nurse supervisor (CNS)-A, and noted there was no signage posted or information regarding the licensee's EPP. On January 17, 2023, at 2:00 p.m., licensed assisted living director (LALD)-B stated the EPP was not posted, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 12 (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 and record review, the licensee failed to provide the required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to 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 the potential to affect a large portion or all residents). The findings include:	0 810		

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0 810	Continued From page 13 On January 20, 2023, from approximately 11:00 a.m. to 12:30 p.m., survey staff toured the facility with the housing coordinator (HC)-F, the environmental services director (ESD)-H, and the office manager (OM)-G. During the facility tour, survey staff observed the posted exit diagrams did not show the location and number of resident rooms. Plans were not labeled or numbered. HC-F, ESD-H, and OM-G verbally confirmed survey staff observations during the facility tour. During interview on January 20, 2023, at 12:45 p.m., HC-F stated they currently perform two evacuation drills per year and do a monthly tabletop education with staff and residents regarding fire safety and evacuation. The current evacuation drill schedule does not comply with the statute. Review of the fire safety and evacuation policy showed the following: 1. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. There was no language in the policy regarding staff training. 2. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. There was no language in the policy regarding resident training. 3. Record of required employee evacuation drills showed insufficient number of drills completed by	0 810		

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0 810	Continued From page 14 time of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the	0 920		

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0 920	Continued From page 15 required content for two of two residents (R1 and R2). This had the potential to affect all 16 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 the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - a disclosure of the category of assisted living facility license held by the facility. R1 R1's diagnoses included dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. R1's Resident Rental Agreement dated September 26, 2022, lacked the above required content. R2 R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration.	0 920		

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0 920	Continued From page 16 R2's Resident Rental Agreement dated February 8, 2022, lacked the above required content. On January 20, 2023, at approximately 9:30 a.m., licensed assisted living director (LALD)-B stated the contract lacked the disclosure of the category of assisted living facility held by the facility, and said the same contract was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an	0 930		

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0 930	Continued From page 17 unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and R2). This had the potential to affect all 16 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 of the residents). The findings include: The licensee failed to provide a contract to include: - a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. R1 R1's diagnoses included dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. R1's Resident Rental Agreement dated September 26, 2022, included the names, but lacked the contact information of the person	0 930		

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0 930	Continued From page 18 representing the facility who is designated to handle and resolve complaints. R2 R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. R2's Resident Rental Agreement dated February 8, 2022, included the names, but lacked the contact information of the person representing the facility who is designated to handle and resolve complaints. On January 20, 2023, at approximately 9:30 a.m., licensed assisted living director (LALD)-B stated the contract lacked the above required content, and said the same contract was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01440 SS=F	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	01440		

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01440	Continued From page 19 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 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 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 began working for the licensee for two of two unlicensed personnel (ULP-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-C and ULP-E's records lacked evidence to	01440		

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01440	Continued From page 20 document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks as required. ULP-C ULP-C was hired on September 21, 2021, to provide direct care and assisted living services to the licensee's residents. ULP-C's record lacked the above required content. ULP-E ULP-E started employment on January 11, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's record lacked the above required content. On January 19, 2023, at at approximately 3:40 p.m., clinical nurse supervisor (CNS)-A stated nursing informally conducted check-ins and audits, but nothing was documented for any of the ULP. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated reviewed August 16, 2022, noted the supervision of ULP by the registered nurse (RN) would be direct supervision of the staff performing a delegated task within 30 calendar days after the staff began working and first performed the delegated resident task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 22 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of three employees (unlicensed personnel (ULP-E)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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-E started employment on January 11, 2017,	01470		

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01470	Continued From page 23 under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's employee record lacked documented evidence of the following: - principles of person-centered planning/service delivery; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On January 19, 2023, at approximately 3:40 p.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-B, and LALD-D reviewed the record with the evaluator. ULP-E's employee record contained a New Employee Orientation, Policy, Procedure, and Checklist which was dated August 17, 2020. LALD-D stated the above required topics were not reviewed with ULP-E after the August 1, 2021, changes. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated reviewed August 16, 2022, noted all staff must complete an orientation to assisted living facility licensing requirements to include principles of person-centered planning and service delivery and how they apply to direct support services and the types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01620	Continued From page 24	01620		
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 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) assessed two of two residents (R1 and R2) with falls, for causative factors to determine individualized interventions to reduce the resident's risk for injury. 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	01620		

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01620	Continued From page 25	01620		

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:

R1
R1's diagnoses included dementia.

R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration.

R1's Tenant [resident] Assessment and Care Plan Guide dated October 19, 2022, noted no falls in the past year, resident required assistance for stability, and assistance with toileting.

On January 17, 2023, at 3:05 p.m., the evaluator observed R1 standing in the common area talking with staff.

R1's Progress Note dated October 13, 2022, authored by clinical nurse supervisor (CNS)-A noted R1 had a fall on October 12, 2022, at 10:15 a.m. The note indicated staff heard a holler from her [R1's] room, and found her on the floor near the bathroom door with the walker by the closet. It noted R1 was unable to state what had happened. CNS-A indicated there were no injuries with follow-up, R1 was able to ambulate per usual and range of motion was within normal limits. Interventions indicated; staff notified nurse who observed for injuries then assisted resident up from the floor with the lift and two staff assist. The note indicated no further concerns, however,

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01620	Continued From page 26 lacked documentation of individualized interventions to reduce R1's risk for injury. R2 R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. R2's Tenant Assessment and Care Plan Guide dated November 17, 2022, noted R2 had a history of falls, was independent with ambulation and transferring, and required assistance with toileting. On January 17, 2023, at 3:15 p.m., the surveyor observed R2 in the hall by the main entrance door. R2 was sitting in a chair and stated she was waiting for her daughter to come from the other side of the door. R2's Incident Reports and Progress Notes noted the following: - October 11, 2022, at 6:15 a.m., R2 had a witnessed fall in the dining room. Staff called nurse, and the nurse checked R2's vital signs. No injuries were noted. R2 was then assisted to get up with a lift and put in bed. CNS-A completed the follow up with R2 and staff. No new interventions were put into place. Under the section marked "Action(s) Taken to Prevent reoccurrence:" staff documented "staff report, resident appeared very tired but had been refusing to go to bed when encouraged throughout the night - wandering & active." - November 29, 2022, at 8:45 p.m., resident had a witnessed fall with a seizure. R2 sustained a	01620		

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01620	Continued From page 27 rug burn to left knee and bump on back of her head. CNS-A and physician notified. R2 was assisted to bed, an ice pack applied to the bump on her head, and Ativan as needed was administered. CNS-A completed the follow up with R2 and staff. Noted R2's knees buckle and she loses balance with a seizure. Range of motion (ROM) and activities of daily living (ADL) were back to within normal limits (WNL). Discussed as needed use of Ativan with physician, and will continue to use and monitor any relation to falls. The section marked "Action(s) Taken to Prevent reoccurrence:" was left blank. - December 30, 2022, at 9:10 p.m., R2 had an unwitnessed fall and hit her head on the floor in her room. Emergency medical technician (EMT) staff came and determined R2 did not need to go in to the hospital. CNS-A completed the follow up with resident and staff and documented R2 was observed to have an intact scab to the back of her head. No bleeding or other injuries. ROM and ALDs WNL. The section marked "Action(s) Taken to Prevent reoccurrence:" noted "Resting in bed." On January 19, 2023, at 8:55 a.m., licensed assisted living director (LALD)-B stated after a fall, a follow up assessment was done, which was currently documented in the progress notes. On January 19, 2023, at approximately 10:25 a.m., CNS-A stated after a fall, the nurse does look at the incident and looks at what happened and if any new interventions are needed. However, she stated they did not currently documented this action for any falls. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620		

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01620	Continued From page 28 (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; (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 interview and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1	01650		

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01650	Continued From page 29 and R2). 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: R1 R1 admitted for services on October 5, 2022, with diagnoses including dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. The agreement lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that included: - identification of and information as to who has authority to sign for the resident in an emergency; and - 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. R2 R2 admitted for services on March 1, 2022, with diagnoses including dementia and schizophrenia.	01650		

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01650	Continued From page 30 R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. The agreement lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan that included: and - identification of and information as to who has authority to sign for the resident in an emergency. On January 19, 2023, at approximately 10:25 a.m., clinical nurse supervisor (CNS)-A stated the service plan lacked the required content, and said the same form was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice	01690		

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01690	Continued From page 31 standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN). 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).	01690		

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01690	Continued From page 32 The findings include: During the entrance conference on January 17, 2023, at approximately 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. At this time, the evaluators requested to review the licensee's current medication policies and procedures. On January 17, 2023, at 11:55 a.m. licensed assisted living director (LALD)-B provided a binder with policies. The licensee later provided eleven medication related policies dated January 18, 2023. However, the licensee lacked the following policies: - verifying that prescription drugs are administered as prescribed; - monitoring and evaluating medication use; - resolving medication errors; - communicating with the pharmacist, and resident and legal and designated representatives; and - educating residents and legal and designated representatives about medications. On January 20, 2023, at approximately 9:30 a.m., LALD-B stated they lacked the above policies, and added the policies she had provided were dated January 18, 2023, and reviewed by her after the survey had started. In addition, LALD-B stated they oversaw many different buildings and were in the process of getting the necessary policies in place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690		

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01730	Continued From page 33	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 34 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication plan to include documentation of specific resident instructions relating to the administration of medications for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 17, 2023, at approximately 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to their residents. On January 19, 2023, at 8:30 a.m., the evaluator observed unlicensed personnel (ULP)-E crushed medications for R1. ULP-E brought the crushed medications to the kitchen area and placed them inside an omelet. She then cut up the omelet and buttered toast. ULP-E stated there was an order to crush R2's medications and she typically	01730		

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01730	Continued From page 35 placed the medications in the resident's food since she does not like sweets or applesauce. ULP-E then brought the plate with the food and medications inside the omelet to the table, and assisted R1 to eat all of her breakfast. R1's diagnoses included dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. R1's Need for Medication Management Services, identified by CNS-A as the medication assessment, dated October 19, 2022, noted the resident required assistance with administration of medications. R1's Client [Resident] Individualized Medication Management Plan dated September 26, 2022, noted R1 received medication administration as scheduled and as needed. However, it lacked specific instructions relating to the administration of medications to include crushing the medications or placing them in food. R1's prescriber orders dated January 11, 2023, included two medications for hypertension and one allergy medication R1's January 2023 Medication Administration Record listed medications as prescribed, times to administer, and staff initials on each date through January 18, 2023, to indicate the medications had been given. On January 19, 2023, at approximately 10:25 a.m., CNS-A stated R1's medications should not be placed into her food, but may be placed in a	01730		

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01730	Continued From page 36 small amount of applesauce or something similar. In addition, CNS-A stated there was a chance R1 would not receive the full amount of medication if she did not eat her entire omelet. CNS-A also stated there was no specific instructions in the resident's record for staff to crush the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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01910	Continued From page 37	01910		

licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R4) upon discharge.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R4 discharged from the facility after passing away on November 19, 2022. R4's record lacked a discharge summary.

R4's Medication Disposition/Disposal Record contained information about one medication, Melatonin which was disposed in the medication safe on November 22, 2022. The record contained no additional information related to any medications disposed of after that date.

R4's prescriber orders dated September 28, 2022, included orders for aspirin, calcium carbonate, famotidine, lidocaine patch, melatonin, metoprolol, rivastigmine patch, sennosides, Tylenol, and Voltaren gel.

R4's record lacked documentation of the disposition of the medications including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the

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01910	Continued From page 38 disposition. On January 19, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the referenced disposition record was the only documentation available for R4's medications. CNS-A stated some medications were sent to pharmacy for a refund, but the licensee did not have a list of the medications, or the required documentation. The licensee's Disposition or Disposal of Medications policy dated reviewed April 2020 noted prescription drugs managed and secured by the licensee and left with the licensee after death or termination of services must be disposed of in the medication safe by the registered nurse (RN) or licensed practical nurse (LPN) with one other person as a witness. It also noted documentation of the destruction, listing the date, quantity, name of the medication, prescription number, signature of the person destroying the medication and signature of witness to the destruction must be recorded in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a	01930		

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01930	Continued From page 39 registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment and therapy management policies and procedures under the supervision and direction of a registered nurse (RN). 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 January 17, 2023, at approximately 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy management services to the licensee's residents. At this time, the evaluators requested to review the licensee's current treatment and therapy policies and	01930		

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01930	Continued From page 40 procedures. On January 17, 2023, at 11:55 a.m. licensed assisted living director (LALD)-B provided a binder with policies. The licensee later provided five treatment related policies dated January 18, 2023. However, the licensee lacked the following policies: - providing the treatment or therapy; - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; and - monitoring and evaluating the treatment or therapy. On January 20, 2023, at approximately 9:30 a.m., LALD-B stated they lacked the above policies, and added the policies she had provided were dated January 18, 2023, and reviewed after the survey had started. In addition, LALD-B stated they oversaw many different buildings and were in the process of getting the necessary policies in place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25904	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

(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
02110	Continued From page 41 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and provided to each resident and the residents' legal and designated representative at the time of move-in. This had the potential to affect all current residents, staff, and visitors.	02110		

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02110	Continued From page 42 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. The licensee lacked evidence the following required policies and procedures related to the dementia care had been developed and provided to each resident and/or the resident's legal and designated representative: - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications. On January 19, 2023, at approximately 10:25 a.m., clinical nurse supervisor (CNS)-A stated the licensee lacked the above required policy. In addition, CNS-A stated the policies were not provided to any of the residents and the residents' legal and designated representative at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02170	Continued From page 43	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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	25904	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

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02170	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1 and R2) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. R1 R1's diagnoses included dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. R1's undated Getting to Know You Questionnaire noted R1's past and current interests. However, it lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25904	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 45 participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate. R2 R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. R2's undated Getting to Know You Questionnaire noted R2's past and current interests. However, it lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate. On January 19, 2023, at approximately 10:25 a.m., clinical nurse supervisor (CNS)-A said the above required content was not included in the questionnaire and the same format was utilized for all residents. CNS-A also stated an individualized activity plan had not been	02170		

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	25904	A. BUILDING: _____ B. WING _____	01/20/2023

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02170	Continued From page 46 developed by the activity department as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for two of two residents (R1 and R2). 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).	02180		

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	25904	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02180	Continued From page 47 The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. R1 R1's diagnoses included dementia. R1's Service Agreement dated September 26, 2022, noted services which included assistance with bathing, dressing and grooming, and medication administration. However, it lacked identification of R1's behaviors. R1's Tenant [Resident] Assessment and Care Plan Guide dated October 19, 2022, noted R1 was anxious, irritable, forgetful, and disoriented. R2 R2's diagnoses included dementia and schizophrenia. R2's Service Agreement dated February 8, 2022, noted services which included assistance with bathing, dressing and grooming, toileting, and medication administration. However, it lacked identification of R2's behaviors. R2's Tenant Assessment and Care Plan Guide dated November 17, 2022, noted R2 was anxious and hyperactive. On January 19, 2023, at approximately 10:25 a.m., clinical nurse supervisor (CNS)-A stated the behavior charting consisted of marking a yes or no if there was a behavior, and if yes was selected, the same list or options of interventions were available for all residents, and was not individualized for any of the residents.	02180		

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02180	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, an accurate description of the dementia care training program with the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with	02260		

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02260	Continued From page 49 Dementia Care (ALFDC) license effective August 1, 2022. During the entrance conference on January 17, 2023, at 10:10 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated the licensee had a locked dementia unit. The licensee's Philosophy of Service Provision - mission, Values, Person-centered Care policy dated August 16, 2022, noted all staff would be trained in house to meet the minimum requirements. It noted the training included an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. However, it lacked information on person-centered planning and service delivery. On January 20, 2023, at 10:00 a.m., licensed assisted living director (LALD)-B stated the policy did not note the inclusion of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *01/18/23*
Time: 10:00:40
Report: 1008231002

Food and Beverage Establishment Inspection Report

Location:
Bridgewell Assisted Living
410 West Main Street
Osakis, MN56360
Douglas County, 21

Establishment Info:
ID #: 0039177
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3208592142
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.

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC KITCHEN. TCS FOOD STORED IN CHEST FREEZER, MAINLY BREAKFAST FOODS. WITHOUT A COMMERICAL KITCHEN ALL TCS FOODS SHALL BE CATERED IN FOR ALL MEALS OR ONLY HELD WITHIN THE ESTABLISHMENT FOR A MAX OF 24 HOURS.

Comply By: 01/19/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

DISHWASHER IN SOUTH KITCHEN IS NOT WORKING. REPAIR OR REPLACE DISHWASHER.

Comply By: 02/01/23

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

CRUMBS AND STICKY RESIDUAL AROUND MICROWAVES IN BOTH KITCHENS. CLEAN THIS NON-FOOD-CONTACT AREA.

Comply By: 01/19/23

Type: Full
Date: *01/18/23*
Time: 10:00:40
Report: 1008231002
Bridgewell Assisted Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: DRESSING - NORTH KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SANDWICH - SOUTH KITCHEN
Violation Issued: No

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

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008231002 of 01/18/23.

Certified Food Protection Manager: Max D. Bogenrief

Certification Number: FM49666 Expires: 07/10/24

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us