DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 23, 2023

Licensee
Parker Oaks Senior Living
211 6th Street Northwest
Winnebago, MN 56098

RE: Project Number(s) SL30463015

Dear Licensee:

On February 24, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 27, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Electronically delivered

December 28, 2022

Licensee
Parker Oaks Senior Living
211 6th Street Northwest
Winnebago, MN 56098

RE: Project Number(s) SL30463015

Dear Licensee:

On December 20, 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 27, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the October 27, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 27, 2022, found not corrected at the time of the December 20, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) = $3,000

The details of the violations noted at the time of this follow-up evaluation completed on December 20, 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.

Also, at the time of this follow-up evaluation completed on December 20, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 = $3,000

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000**. 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 Jessica Chenze at 218-332-5175.

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,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30463	A. BUILDING: _____ B. WING _____	R 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS SENIOR LIVING	211 6TH STREET NW WINNEBAGO, MN 56098

(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 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30463015-1 On December 19, 2022, through December 20, 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 27, 2022. At the time of the survey, there were 38 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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.	
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the tag identification order 1380, for a revisit survey completed on December 20, 2022. 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	0 340		

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0 340	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The findings include: During the revisit survey on December 19, 2022, the surveyor reviewed the licensee's policies and procedures, and conducted interviews with licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A, registered nurse (RN)-B and unlicensed personnel (ULP)-H, ULP-N. The licensee lacked evidence to indicate tag identification order 1380, issued on October 26, 2022, was corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: No further action required.	{0 570}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	{0 650}		

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{0 650}	Continued From page 4 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	{0 680}		

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{0 680}	Continued From page 5 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	{0 730}		

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{0 730}	Continued From page 6 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required.	{0 730}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		

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{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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{01380}	Continued From page 8	{01380}		
{01380} SS=I	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-N, ULP-M completed training and competency evaluations for all required areas prior to providing services. 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:	{01380}		

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{01380}	Continued From page 9 ULP-N ULP-N started employment on August 17, 2022, to provide direct care under the licensee's Assisted Living License. ULP-N's employee record contained a 43-page document titled Assisted Living/Minnesota: Orientation Checklist-Caregiver; and the document included: -ULP-N's name, facility name, position, location and hire date: August 17, 2022; -the third page of the orientation checklist was signed by licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A, registered nurse (RN)-B, ULP-N, dated October 17, 2022; -page four included ULP-N's name at the top, dated October 17, 2022; -pages four through 43 included skill competencies which included 80 pass/fail check boxes for procedures; all of the 80 boxes were checked as passed. Of the 39 pages, there were 21 opportunities for the evaluator signature, date, and title: 21 of the 21 opportunities were blank. R1 R1's Service plan dated July 5, 2022, identified R1 received the following services medication administration, behavior management, catheter management, skin treatment, vital sign monitoring, safety checks, laundry and housekeeping services. R1's treatment recap summary dated November 1, 2022, through November 30, 2022, indicated ULP-N provided R1's catheter care on December 10, 12, 14, 15, 22, 26, and 29, 2022. R1's medication administration record (MAR)	{01380}		

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{01380}	Continued From page 10 dated December 1, 2022, through December 20, 2022, indicated ULP-N administrated R1's morning medications on December 11, 2022. On December 19, 2022, at 2:23 p.m., ULP-N stated she did Educare training (on-line training), watched slide shows and had some in person training, "this is how you would do it" from RAs [resident assistant]/ULPs. ULP-N named three ULPs she had worked with during her training period. ULP-N stated "the RN did not show me," "all my training was done on the weekend." ULP-N stated the RAs/ULPs showed her how to perform tasks, later the RN "walked" ULP-N through "it" [training/skills], "asking how I was able to, how I did, and I walked her through, "oh hey this is how you would do a blood pressure cuff." ULP-M ULP-M started employment on May 13, 2022, to provide direct care under the licensee's Assisted Living License. ULP-M's employee files contained a 43-page document titled Assisted Living/Minnesota: Orientation Checklist-Caregiver; and the document included: -ULP-M's name, facility name, position, and location; -the third page of the orientation checklist was signed by LPN/LALDIR-A, RN-B, ULP-M, dated August 2, 2022; -page four included ULP-M's name at the top of the page, dated August 2, 2022; -pages four through 43 were skill competencies which included 80 pass/fail check boxes for procedure; all of the 80 boxes had been checked as passed. On the 39 pages there were 21 opportunities for the evaluator signature, date,	{01380}		

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{01380}	Continued From page 11 and title: 21 of the 21 opportunities were blank. R3 R's Service plan dated October 25, 2022, identified R3 received the following services medication administration, compression stocking assist, blood glucose transmitter assist/testing, oxygen, judgment assistance, vital sign monitoring, safety checks, laundry and housekeeping services. R3's treatment recap summary dated November 1, 2022, through November 30, 2022, indicated ULP-M provided R3's blood sugar testing the evening of November 4, 11, 26. R3's MAR dated December 1, 2022, through December 20, 2022, indicated ULP-N administered R3's afternoon oral medication and R3's insulin on December 16, 2022. On December 20, 2022, at 8:06 a.m., RN-B stated the facility's training process was "once the girls are on the floor, we have kind of a list of the types of things the aids go through with them. Experienced RAs/ULPs show them the things "we" do. "Transferring, activities of daily living (ADLs), colostomies, oral cares, positioning in bed, vital signs, so they are comfortable with that. Ted hose (compression stocking) they have to do those things, blood sugar testing, insulin, hand washing." RN-B stated she reviews with the experienced RAs/ULPs if the new staff have issues. RN-B added, "I try to observe." RN-B stated the "trainers" are "long term RAs/ULPs, with lots of experience." RN-B stated new RAs/ULPs start with observation and depending on their history, "sometimes we hire "long term/experienced" staff, sometimes they observe, or it they feel comfortable the RA/ULP will watch	{01380}		

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	30463	A. BUILDING: _____ B. WING _____	R 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01380}	Continued From page 12	{01380}		

when they do something." RN-B added medications are also done the same way, observation first, administer when comfortable. RN-B stated "skills" [competencies] are done with newly hired ULPs by RN before they (ULPs) are scheduled to work out on the floor by themselves. RN-B added, "We go through that with everybody, review if we have to."

On December 20, 2022, at 10:42 a.m., LPN/LALDIR-A, vice president of assisted living (VP)-F, and LPN/LALD-O acknowledged the facilities hiring and training process for new staff failed to meet requirements.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, included unlicensed personnel that will provide assistance with medication, treatment, and therapy administration will be trained and competency tested by the RN. Medications, treatment and therapy always need to be administered according to the "6 Rights";
a. Right person
b. Right medication, treatment or therapy
c. Right time
d. Right route
e. Right dose
f. Right chart/record to document the medication, treatment, and therapy was taken.

The licensee's Training Unlicensed [sic] Personnel for Medication, Treatment and Therapy Administration policy dated August 1, 2022, identified before the RN delegates the task of medication administration, treatment, and therapy the RN would instruct the ULP on performing these tasks and determine the ULP as competent to perform the tasks. The RN would document the training and competency of ULP to

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{01380}	Continued From page 13 competently administer each type of service they are assigned in the staff person's personnel record. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted a RN may delegate nursing services to unlicensed personnel that have successfully completed the training required, have been trained in the services to be provided, have demonstrated to the RN or licensed health professional the ability to competently follow the procedures for the resident, and possess the knowledge and skills consistent with the complexity of the tasks. Before delegating or assigning a task to ULP, the RN or licensed health professional must determine that each staff member who will perform the task is trained and competent to perform the task and has been instructed in the proper procedures for performing the procedures with respect to the specific resident. The RN and/or licensed health professional will assure that training and competency records for all ULP's are kept up-to-date and are easily accessible to the RN or licensed health professional so the RN or licensed health professional can determine which staff is competent to perform various delegated tasks. No further information was provided.	{01380}		
{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	{01470}		

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{01470}	Continued From page 14	{01470}		

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 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;

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{01470}	Continued From page 15 (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: No further action required.	{01470}		
{01650} SS=D	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	{01650}		

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{01650}	Continued From page 16 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: No further action required.	{01650}		
{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: No further action required.	{01770}		
{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	{01940}		

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{01940}	Continued From page 17 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 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{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 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.	{01960}		

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{01960}	Continued From page 18 This MN Requirement is not met as evidenced by: No further action required.	{01960}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action required.	{01970}		

Electronically Delivered

November 23, 2022

Administrator
Parker Oaks Senior Living
211 6th Street Northwest
Winnebago, MN 56098

RE: Project Number(s) SL30463015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn S-S= I

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	30463	A. BUILDING: _____ B. WING _____	10/27/2022

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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#30463015 On October 24, 2022, through October 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 36 residents; 35 receiving services under the provider's Assisted Living license. 1380: An immediate correction order was issued on October 26, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 24, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 570	Continued From page 2	0 570		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On October 24, 2022, at approximately 9:15 a.m. upon entering the facility, the license was not observed to be posted at the facility entrance as required. On October 24, 2022, at approximately 10:15 a.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A confirmed the original current license was posted in a hallway by a sitting area and the employee breakroom, and not at the front entrance as required. LPN/LALDIR-A further stated the main entrance used to be located next to this area but	0 570		

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0 570	Continued From page 3 after an addition a couple of years ago, the front entrance was moved. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation,	0 650		

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0 650	Continued From page 4 employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel's (ULP-D)record included records of competency evaluations as required. 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-D began providing direct care services for the licensee on June 29, 2022. ULP-D's record lacked evidence of competency evaluation requirements. On October 26, 2022, at 12:16 p.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A stated prior to July 2022, they hadn't completed competency testing for the unlicensed personnel that were observed and signed off by a registered nurse (RN); they had a checklist. The facility did a reset and LPN/LALDIR-A and RN-G went through the packet of competencies with all ULP, and remembered completing with ULP-D. LPN/LALDIR-A wasn't sure why evidence of ULP-D competencies couldn't be located.	0 650		

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0 650	Continued From page 5 On October 26, 2022, at 12:47 p.m. ULP-D confirmed she had completed competency testing for medications and treatments with the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 27, 2022, at 9:20 a.m. the surveyor reviewed the emergency preparedness plan with licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A. The licensee's EP plan consisted of several documents and policies dated June 27, 2022. The plan included a hazard and vulnerability assessment and various policies/procedures. The licensee's plan lacked the following required content: - Emergency prep testing requirements On October 27, 2022, at 9:20 a.m. LPN/LALDIR-A stated the licensee lacked a customized emergency preparedness plan and Appendix Z to include the above requirement. LPN/LALDIR-A indicated she was aware of the emergency preparedness requirements but had	0 680		

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0 680	Continued From page 7 not completed a tabletop or full-scale exercise in the last year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 8 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's record lacked a discharge summary to include: - courses of illnesses, and pertinent lab,	0 730		

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0 730	Continued From page 9	0 730		

radiology, and consultation results; and
- a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, and any arrangements that have been made for the resident's follow-up care

R4 was admitted to the licensee on February 26, 2019, with diagnoses including diabetes, diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), depression, and dementia. R4 discharged from the facility on August 2, 2022.

R4's Resident Notes indicated R4 would be discharging to a different assisted living. The notes also indicated R4 had been hospitalized for pneumonia on July 28, 2022. R4's discharge summary did not include the location of discharge, course of illness requiring hospitalization, and any arrangements for the resident's follow-up care.

On October 24, 2022, at 2:55 p.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A confirmed R4's Discharge Summary did not include evidence of where R4 was discharging to or any arrangements for the resident's follow-up care.

The licensee's Discharge Summary policy dated August 1, 2021, indicated,
4. 'The discharge summary will include, if applicable
    a. Summary of the resident's stay, including
        i. Diagnosis
        ii. Course of illnesses

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0 730	Continued From page 10 iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral and functional status. c. Post discharge plan developed with the resident, and if the resident consents, resident's representatives. d. The post discharge plan will include: i. Resident's planned residence ii. Arrangements made for follow-up care iii. Needed post discharge medical and nonmedical services No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 11 failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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). Findings include: On a facility tour on October 25, 2022, at approximately 11:00 a.m. with Director of Maintenance (DM)-E, the following items were observed: - The south hall furnace room had a large hole in the sheetrock on a wall that abuts a resident room. This wall is part of a fire barrier and is required to be intact to provide the resident room the required fire separation from the furnace room. - The south hall electric room or closet had wires sticking out of the electric panel that were just capped with wire nuts and were not terminated in a required box for safety. - Room #212 had damaged sheetrock and damaged metal corner bead in the doorway leading to the bathroom. The sharp exposed	0 800		

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0 800	Continued From page 12 metal edge is a cut hazard to the resident residing in the room. DM-E visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 13 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills.. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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). Findings include: A record review and interview were conducted on October 25, 2022, at approximately 10:15 a.m. with Director of Maintenance (DM)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not	0 810		

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provide complete actions for employees to take in the event of a fire or similar emergency. During interview, DM-E verified that the fire safety and evacuation plan for the facility lacked these provisions.

Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, DM-E verified that the fire safety and evacuation plan for the facility lacked these provisions.

Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, DM-E verified that the fire safety and evacuation plan for the facility lacked these provisions.

Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, DM-E stated the licensee did not have any documented training or a policy on training employees.

Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the

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0 810	Continued From page 15 event of a fire to include movement, evacuation, or relocation as required by statute. During interview, DM-E stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift. During interview, DM-E verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01380 SS=I	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 16 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three unlicensed personnel (ULP-C, ULP-H) completed training and competency evaluations for all required areas prior to providing services. This resulted in an immediate correction order identified on October 26, 2022, at 1:49 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: R5's diagnoses included edema, type II diabetes with hyperglycemia (high blood sugar), and anxiety disorder. R5's Service Plan dated July 5, 2022, indicated the resident received medication administration services. Email communication to the licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A from registered nurse (RN)-G dated August 15, 2022, at 8:51 a.m. gave an update from the weekend as RN-G had been on-call. The email indicated: Saturday (August	01380		

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01380	Continued From page 17 13, 2022) p.m. shift at PO (Parker Oaks) - notified that R5 received the wrong medications. A new ULP had set them up and was going to administer them, but the resident was outside. The ULP marked the med cup, and put them back in the cart. When R5 came back upstairs, she grabbed the wrong cup and gave it to him [R5]. Instructed noc (night) ULP to watch him. R5 went to bed early, which was not his norm; was very drowsy and a bit out of it. During the night, R5 proceeded to roll out of bed and unsuccessfully self transfer, resulting in multiple falls. The ULP reported R5 was much better the next morning. R5's Incident Report dated August 15, at 8:00 a.m. indicated ULP-C inadvertently gave medications to the wrong resident with failure to verify correct resident/medication/time/route. R5's Provider Update, faxed to provider on August 15, 2022, at 13:18 (1:18 p.m.) indicated: FYI (for your information): August 14, 2022, at 8:00 p.m. R5 was inadvertently given the following medications: amitriptyline (antidepressant) 50 mg (milligrams); atorvastatin (antihyperlipidemic for high cholesterol) 10 mg; Gabapentin (anticonvulsant used to control seizures and also nerve pain) 800 mg; sertraline (antidepressant) 100 mg; Trazodone (antidepressant) 50 mg; and zolpidem (sedative-hypnotic) 10 mg. He also received his scheduled medications including: Tramadol (analgesic opioid agonist used to control pain) 50 mg; Baclofen (skeletal muscle relaxant) 10 mg; and diazepam (anti-anxiety agent) 2 mg. He fell twice during the night attempting to transfer self to commode, without injury. This morning he is feeling "much clearer and stronger." Able to transfer self per usual.	01380		

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01380	Continued From page 18 The staff roster indicated ULP-C started on June 17, 2022. ULP-C's record lacked evidence of training and competency evaluations in all required areas with the RN prior to providing services. On October 26, 2022, at 12:16 p.m. LPN/LALDIR-A stated prior to last July 2022, they hadn't been doing competencies that were signed off on by the registered nurse (RN); they had a checklist. The licensee did a reset and went through the packet of competencies with all of the ULPs and would complete these on Wednesdays with RN-G. LALDIR-A stated she was unable to locate the competencies for ULP-C. On October 26, 2022, at 12:53 p.m. ULP-C stated she did not receive training or completed competency evaluation by the RN for medication and treatment services, and was trained on the floor by other ULP. ULP-C confirmed having a medication error for R5 on August 13, 2022. ULP-C stated the on-call RN-G was notified and indicated she should receive more training. ULP-C stated this was provided by another ULP working on the floor that evening, but she had not received training from a RN. ULP-C stated she had only worked once since August 14, 2022, and confirmed when she worked she passed medications. ULP-C further confirmed she did not receive any training by the RN on the day she came back to work. ULP-H ULP-H had a hire date of September 1, 2022. ULP-H's employee record lacked evidence of training and competency in all required areas with the RN prior to providing services.	01380		

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01380	Continued From page 19 Review of the licensee's schedule dated October 3, 2022, through October 21, 2022, identified ULP-H was scheduled with another ULP; however, on October 22, 2022, and October 23, 2022, the licensee's schedule identified ULP-H worked independently. On October 26, 2022, at 2:55 p.m. LPN/LALDIR-A stated there was no training or competency on file for ULP-H and verified it should have been completed with the RN prior to ULP-H providing services independently. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, included unlicensed personnel that will provide assistance with medication, treatment, and therapy administration will be trained and competency tested by the RN. Medications, treatment and therapy always need to be administered according to the "6 Rights"; a. Right person b. Right medication, treatment or therapy c. Right time d. Right route e. Right dose f. Right chart/record to document the medication, treatment, and therapy was taken. The licensee's Training Ulicensed [sik] Personnel for Medication, Treatment and Therapy Administration policy dated August 1, 2022, identified before the RN delegates the task of medication administration, treatment, and therapy the RN would instruct the ULP on performing these tasks and determine the ULP as competent to perform the tasks. The RN would document the training and competency of ULP to competently administer each type of service they	01380		

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01380	Continued From page 20 are assigned in the staff person's personnel record. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted a RN may delegate nursing services to unlicensed personnel that have successfully completed the training required, have been trained in the services to be provided, have demonstrated to the RN or licensed health professional the ability to competently follow the procedures for the resident, and possess the knowledge and skills consistent with the complexity of the tasks. Before delegating or assigning a task to ULP, the RN or licensed health professional must determine that each staff member who will perform the task is trained and competent to perform the task and has been instructed in the proper procedures for performing the procedures with respect to the specific resident. The RN and/or licensed health professional will assure that training and competency records for all ULP's are kept up-to-date and are easily accessible to the RN or licensed health professional so the RN or licensed health professional can determine which staff is competent to perform various delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On October 27, 2022, the immediacy of correction order 1380 was removed; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	01380		

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01470	Continued From page 21	01470		
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	01470		

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01470	Continued From page 22 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-C) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on June 17, 2022, to provide	01470		

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01470	Continued From page 23 direct care services to the licensee's residents. ULP-C's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning and service delivery. On October 26, 2022, at approximately 10:00 a.m. licensed practical nurse/licensed assistant living director in residence (LPN/LALDIR)-A verified ULP-C had not completed all components of the required orientation training.	01470		

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01470	Continued From page 24 The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff dated August 1, 2021, indicated: 1. All assisted living employees must complete and orientation to assisted living facility licensing requirements and regulations before providing services to residents. 2. At minimum, orientation must include the following topics: a. An overview of Minnesota's assisted living law. b. An introduction and review of agency policies and procedures related to the provision of assisted living services. j. Principles of person-centered planning and service delivery and how they apply to direct support services. l. Maltreatment of vulnerable adults. m. How to report maltreatment of vulnerable adults. n. How to report a crime. o. Complaint process Handling resident complaints. The facility's system for receiving and responding to complaints. Where and how to report complaints. Contact information for the Office of Health Facility Complaints. Contact information for the Office of the Ombudsman for long-term care. Contact information for the Office of the Ombudsman for Mental Health and Disabilities No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		

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01650	Continued From page 25	01650		
01650 SS=D	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 the service plan included all the required content for one of three residents (R3).	01650		

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01650	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's service plan dated January 22, 2018, identified R3 received medication management services, treatments per prescriber orders, laundry, and light housekeeping. On October 24, 2022, at approximately 11:30 a.m. unlicensed personnel (ULP)-L was observed to check R3's blood sugar and administer insulin. R3's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: information and a method to contact the facility. On October 25, 2022, at 4:05 p.m. licensed practical nurse/ licensed assisted living director in residence (LPN/LALDIR)-A verified the content was lacking on R3's service plan and stated R3 had an old version of the service plan. LPN/LALDIR-A indicated the facility had "reset" all the forms this summer but R3 had been in the hospital during that time and his paperwork had been set aside and not updated or completed.	01650		

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01650	Continued From page 27 The licensee's Contents of Service Plans policy dated August 1, 2021, noted the service plan would include: - schedule and methods of monitoring assessments; - schedule and methods of monitoring staff providing services; and -a contingency plan that includes: information and method to contact the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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 interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01770		

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01770	Continued From page 28 situation has occurred only occasionally). The findings include: During the entrance conference on October 24, 2022, at 9:35 a.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR) stated the licensee provided medication management services to the licensee's residents, including medication setup. R1's Service Plan (Waiver) - Addendum to Contract dated August 1, 2021, with an effective date of July 5, 2022, indicated R1 received services including medication administration. R1's 90-day assessment dated August 4, 2022, identified R1 needed full medication management and set up of medications. R1's prescriber orders dated March 10, 2022, included the following order: Ingrezza (for tardive dyskinesia- uncontrollable or involuntary movements that can occur anywhere in the body) 40 milligrams (mg) by mouth once daily in med minder (a pillbox that has medications arranged by time of day). On October 25, 2022, at 11:20 a.m. unlicensed personnel (ULP)-J stated R1 had one medication in a med minder that the registered nurse (RN) set up for the ULP to administer each morning per electronic medication administration record (eMAR). R1's October 2022, med setup medication administration record (MAR) lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and	01770		

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01770	Continued From page 29	01770		

route of administration.

On October 26, 2022, at 9:20 a.m. vice president of assisted living (VP)-F stated the licensed nurse failed to sign off she had set the medications up. VP-F indicated the medications had been set up but had not been documented by the nurse. VP-F further stated her expectation was for medications to be signed off at the time of set-up.

The licensee's 7.09 Medication Management - Dosage Box Setup policy dated December 28, 2021, included:
1. A licensed nurse will assure the medication orders are transcribed onto the MAR. This profile includes:
   a. dates of medication set up
   b. medication name
   c. quantity of dose
   d. times to be administered
   e. route of administration
   f. name of the person completing the medication setup
   g. visual description of medication
   h. drug classification and special precautions.
4. The licensed nurse sets up medication weekly into the dosage boxes.
5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR, under clinical review in Rtasks (computer software program).

No further information was provided.

TIME PERIOD TO CORRECT: Seven (7) Days

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01940	Continued From page 30	01940		
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 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an individualized treatment management plan to include all required content for one of two	01940		

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01940	Continued From page 31 residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 24, 2022, at 9:35 a.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A confirmed the licensee provided treatment and therapy services to the licensee's residents. R3's diagnoses included congestive heart failure (heart's capacity to pump blood cannot keep up with the body's need) and edema (swelling caused due to excess fluid accumulation in the body tissues). On October 24, 2022, at 2:43 p.m. R3 was observed wearing a TED (thrombo-embolic deterrent) hose (compression socks used to increase circulation and reduce swelling in the legs) to his right lower leg. R3 stated staff put the TED socks on every day and remove at night. R3 further clarified the left sock was still damp this morning so only the right sock was applied. R3's hospital readmission assessment completed August 18, 2022, identified R3 needed help with getting TED hose on and off.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30463	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 32 R3's service plan dated January 22, 2018, identified R3 received medication management services, treatments per prescriber orders, laundry, and light housekeeping. R3's Treatment or Therapy Management Plan dated January 22, 2018, included TED hose daily by unlicensed staff. The plan further indicated a RN would monitor and supervise the service daily. The treatment or therapy management plan lacked: -documentation of specific resident instructions relating to the treatments or therapy administration; -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 documenting of treatment and therapy received and verification that all treatment and therapy was administered as prescribed. R3's record lacked prescriber orders for TED hose. On October 25, 2022, at 3:40 p.m. unlicensed personnel (ULP)-K stated R3 wore TED hose every day and he needed assistance to remove them each evening. ULP-K was unable to show surveyor where the task of removing the TED hose was documented stating "maybe we are just so used to doing it we don't even think about documenting it". On October 25, 2022, at 4:05 p.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A stated R3 wore TED hose applied and removed by staff each day and verified it was not documented in R3's record.	01940		

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01940	Continued From page 33 LPN/LALDIR-A further stated the service plan and treatment plan were from 2018 and lacked required content. LPN/LALDIR-A indicated the facility had "reset" all the forms this summer but R3 had been in the hospital during that time and his paperwork had been set aside and not updated or completed. The licensee's 7.05 Treatment & Therapy Management Plan policy dated December 21, 2021, identified [The Licensee] would develop and maintain a current individualized treatment and therapy management record for each resident which would contain at least the following: b. documentation of specific resident instructions relating to the treatments or therapy administration d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident specific requirements relating to documentation of treatments and therapy received. 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	01960		

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01960	Continued From page 34	01960		

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

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review the licensee failed to document treatments for one of two residents (R3).

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

The findings include:

R3's diagnoses included congestive heart failure (heart's capacity to pump blood cannot keep up with the body's need) and edema (swelling caused due to excess fluid accumulation in the body tissues).

On October 24, 2022, at 2:43 p.m. R3 was observed wearing a TED (thrombo-embolic deterrent) hose (compression socks used to increase circulation and reduce swelling in the legs) to his right lower leg. R3 stated staff put the TED socks on every day and remove at night. R3 further clarified the left sock was still damp this morning so only the right sock was applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 35 R3's Treatment or Therapy Management Plan dated January 22, 2018, included TED hose daily by unlicensed staff. R3's record lacked prescriber orders for TED hose. On October 25, 2022, at 3:40 p.m. unlicensed personnel (ULP)-K stated R3 wore TED hose every day and he needed assistance to remove them each evening. ULP-K was unable to show the surveyor where the task of removing the TED hose was documented stating "maybe we are just so used to doing it we don't even think about documenting it". On October 25, 2022, at 4:05 p.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A stated R3 wore TED hose applied and removed by staff each day and verified it was not documented in R3's record. The licensee's 7.05 Treatment & Therapy Management Plan policy dated December 21, 2021, indicated the licensee would develop and maintain a current individual treatment and therapy management record for each resident, and the record would include verification that all treatment and therapy was administered as prescribed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 21, 2021, included medications, treatment and therapy always need to be administered according to the "6 Rights" f. Right chart/record to document that the medication, treatment, and therapy was taken. The licensee's Documentation of Medication,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 36 Treatment, and Therapy Management Services policy dated August 1, 2021, noted staff would document each task immediately after the task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R3) receiving treatments. 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).	01970		

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01970	Continued From page 37 The findings include: During the entrance conference on October 24, 2022, at 9:35 a.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A confirmed the licensee provided treatment and therapy services to the licensee's residents. R3's diagnoses included congestive heart failure (heart's capacity to pump blood cannot keep up with the body's need) and edema (swelling caused due to excess fluid accumulation in the body tissues). On October 24, 2022, at 2:43 p.m. R3 was observed wearing a TED (thrombo-embolic deterrent) hose (compression socks used to increase circulation and reduce swelling in the legs) to his right lower leg. R3 stated staff put the TED socks on every day and remove at night. R3 further clarified the left sock was still damp this morning so only the right sock was applied. R3's hospital readmission assessment completed August 18, 2022, identified R3 needed help with getting TED hose on and off. R3's service plan dated January 22, 2018, identified R3 received treatments per prescriber orders. R3's Treatment or Therapy Management Plan dated January 22, 2018, included TED hose daily by unlicensed staff. R3's record lacked prescriber orders for TED hose.	01970		

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01970	Continued From page 38 On October 25, 2022, at 4:05 p.m. licensed practical nurse/licensed assisted living director in residence (LPN/LALDIR)-A stated R3 wore TED hose applied and removed by staff each day and verified R3's record lacked an order for the treatment. LPN/LALDIR-A further stated there should be prescriber orders for treatments. The licensee's Medications & Treatment Orders policy dated December 21, 2021, noted the registered nurse (RN) was responsible to assure a current authorized prescriber orders for treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *10/24/22*
Time: 12:07:21
Report: 1028221175

Food and Beverage Establishment Inspection Report

Location:
Parker Oaks Senior Living
211 6th Street Nw
Winnebago, MN56098
Faribault County, 22

Establishment Info:
ID #: 0037899
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078933171
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide test strips for the quaternary ammonium sanitizer and the chlorine sanitizer.

Comply By: 11/01/22

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

Food employees must begin incorporating the above listed procedure into their handwashing routine.

Comply By: 11/01/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Provide a handwashing sign at the handwashing sink in the dish machine area and at the Serving Kitchen handwashing sinks.

Comply By: 11/01/22

Surface and Equipment Sanitizers

Chlorine: = 100ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Serving Kitchen - Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 71 Degrees Fahrenheit - Location: Pork Medallion
Violation Issued: No

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

Process/Item: Walk-In Freezer
Temperature: -5 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: Manitowoc - Ambient
Violation Issued: No

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

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

This Inspection was conducted in conjunction with HRD.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221175 of 10/24/22.

Certified Food Protection Manager: Debra Green

Certification Number: FM40473 Expires: 11/28/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

Linda KuyKendall
Culinary Director

Signed: _____

Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us