DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 7, 2022

Administrator
Oak Terrace North Mankato
1575 Hoover Drive
North Mankato, MN 56003

RE: Project Number(s) SL30836015

Dear Administrator:

On October 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 9, 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,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

October 4, 2022

Administrator
Oak Terrace North Mankato
1575 Hoover Drive
North Mankato, MN 56003

RE: Project Number(s) SL30836015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 9, 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30836	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE NORTH MANKATO	1575 HOOVER DRIVE NORTH MANKATO, MN 56003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30836015 On September 6, 2022, through September 9, 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 76 residents; 75 receiving services under the provider's Assisted Living with Dementia Care license. On September 9, 2022, the immediacy of correction order 1290 has been removed, however non-compliance remains at a scope and level of I (level 3, Widespread).	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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 480	Continued From page 1	0 480		
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 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 September 6, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during toileting 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 situation has occurred only occasionally).	0 510		

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0 510	Continued From page 3 The findings include: R1's Service Plan updated September 2, 2022, indicated R1 required assist of two staff with transferring per Hoyer lift and with toileting (check and change). On September 8, 2022, at 11:16 a.m. unlicensed personnel (ULP)-F and ULP-G were observed providing cares for R1. The ULP each donned gloves and were on opposite sides of R1's bed. The ULP uncovered R1, then ULP-F proceeded to unfasten R1's incontinence brief and provided peri care. The ULP then rolled R1 from side to side to remove the soiled brief and replace it with a clean brief. Prior to fastening the clean brief, the ULP rolled R1 unto her left side. ULP-G held R1 in place while ULP-F applied skin barrier cream to R1's bottom, and then applied lotion to R1's back. The ULP then rolled R1 onto her back; ULP-F fastened R1's brief, and then pulled up R1's pants. ULP-F then obtained a graduate and alcohol wipes from the bathroom. ULP-F applied alcohol to the end of the catheter bag drainage tube then emptied the urine into the graduate. ULP-F then took another alcohol wipe and cleansed the tube again prior to clamping it. ULP-F placed the graduate into R1's bathroom and stated she wasn't going to empty it yet as the urine was a little cloudy and wanted the nurse to look at it. ULP-F then obtained R1's lift sling and placed it alongside the resident and tucked it under her. The ULP rolled R1 from side to side to place the lift sheet. Once the lift sheet was in place, ULP-F removed her gloves (this was the first time she had removed her gloves throughout the observation.) ULP-F then obtained the Hoyer lift and the ULP transferred the resident into her Broda chair. Once R1 was positioned comfortably, ULP-G doffed her gloves and exited	0 510		

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0 510	Continued From page 4	0 510		

the room. ULP-F then donned gloves and proceeded to provide oral cares for R1. Once finished, ULP-F doffed her gloves and brushed R1's hair and stated she would now make up R1's bed and then take her to lunch. While making R1's bed, the surveyor asked at what time she would change her gloves. ULP-F stated after doing peri cares and also stated she would put on clean gloves when doing oral cares. ULP-F confirmed she had not changed gloves after performing R1's peri-care. After making the resident's bed and straightening up R1's room, ULP-F transported R1 out to the dining room in her Broda chair for lunch. ULP-F had not washed or cleansed her hands with sanitizer throughout the entire observation, and further did not cleanse hands when exiting R1's room. ULP-F brought R1 to the dining room then continued to assist with other residents.

On September 9, 2022, at 3:37 p.m. director of nursing (DON)-B confirmed staff should change gloves when working with a resident and coming in contact with body fluids. DON-B further confirmed staff should wash/cleanse hands after glove removal and after working with a resident.

The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated: Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: After changing diapers or cleaning up after someone who has used the toilet.

No further information was provided.

TIME PERIOD TO CORRECT: Seven (7) Days

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0 660	Continued From page 5	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-F) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 660		

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0 660	Continued From page 6 situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated August 2, 2022, indicated the licensee was a low risk. ULP-F was hired July 20, 2022, to provide direct care services. On September 8, 2022, at approximately 11:16 a.m. ULP-F was observed to independently provide oral cares for R1 in her room. ULP-F's employee record contained a negative chest x-ray dated November 18, 2021, for ULP-F; however, ULP-F's employee record lacked evidence of the following: - TB history and symptom screening On September 9, 2022, at 2:58 p.m. director of nursing (DON)-B verified ULP-F's employee file lacked a TB history and symptom screening. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, identified new employees would have a baseline screening for TB according to current CDC recommendations and guidelines. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker)	0 660		

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0 660	Continued From page 7 starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records for one of one resident (R3) for whom they provided services included: verification of admission date, vital signs, clarification of date/data collected for pre-assessment and admission assessment by registered nurse (RN), and authentication of documentation with the name and title of the person making the entry. 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).	0 690		

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0 690	Continued From page 8 The findings include: R3 was admitted on December 29, 2021, with diagnoses including chronic kidney disease, Parkinson's disease, dementia, and depression. R3's record included a Uniform Assessment Tool completed by a RN, that had been copied from the electronic record and hand written on by the nurse who completed it. The top of the assessment included information to complete such as; Client, Initial Admission, Admission, Date of Birth, Gender, and Physician. These had been blacked out (though when looking closely could see R7's name next to "Client") except for the Initial Admission, which indicated a date of September 2, 2019. R3's name was hand-written below this information along with, Admit, and a date of June, 3, 1939. The first page of the assessment also included check boxes related to Assessment, Cognition, Vital Signs, and Medical History. The check boxes had been marked when applicable and hand-written notes were also included. The Vital Signs section had typed information from November 6, 2021, for pain level; December 1, 2021, for weight; December 20, 2021, for blood pressure, pulse, and respirations; and December 27, 2021, for temperature and oxygen saturation (circulation of oxygen through the bloodstream). A diagonal line had been drawn through this information. The bottom of the first page included hand-written dates indicating; December 8, 2021, Assessment and December 29, 2021, Admit Assessment. The assessment did not differentiate what had been completed for each of the dates on the assessment. The last page of the assessment included two illegible signatures dated December 28, 2021, and December 29, 2021; the title of the	0 690		

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0 690	Continued From page 9 person could not be identified through the signatures. On September 8, 2022, at 10:24 a.m. director of nursing (DON)-B confirmed having completed R3's pre-admission and admission assessments. DON-|B further confirmed she had printed off an assessment for another resident (R7) then redacted the person information other than R7's vital signs which had a line through them. DON-B stated R3's vital signs were in the electronic record. DON-B confirmed the assessments completed on December 8, 2021, and December 29, 2021, were all part of the same assessment and did not differentiate what information was collected on each date. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2021 indicated: Oak Terrace will maintain appropriate and accurate records for each resident that is receiving assisted living services. All entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. Resident records whether written or electronic will be protected against loss, tampering, or unauthorized disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 10 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 September 8, 2022, at approximately 2:45 p.m. with Director of Maintenance (DM)-H the following deficient items were observed: There was a broken light cover on a fluorescent light in the Autumn Lane main level laundry room. The radiant heater was missing part of the cover assembly in the Autumn Lane main level laundry	0 800		

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	30836	A. BUILDING: _____ B. WING _____	09/09/2022

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0 800	Continued From page 11 room. There was an open and exposed electric wire over the doorway in the mechanical room that was in the main dining room. There were unterminated and capped electrical wires above the electrical panel in the second level mechanical room. The glass was missing from the fire extinguisher cabinet exposing sharp metal edges in the main level non-locked side corridor. The older style emergency egress lights throughout the facility were not working. There were holes in the sheetrock walls and missing electrical receptacle covers of the main level mechanical room on the non-locked side. There was a circulating pump that was illegally wired with a cut off extension cord in the main level mechanical room on the non-locked side. DM-H 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;	0 810		

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0 810	Continued From page 12 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident training on fire safety and evacuation. 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	0 810		

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0 810	Continued From page 13 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 September 8, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (LALD)-A and Director of Maintenance (DM)-H 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 fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A and DM-H stated 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 include procedures for resident movement, evacuation, or relocation during a fire or similar emergency but did not include the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD-A and DM-H stated 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	0 810		

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	30836	A. BUILDING: _____ B. WING _____	09/09/2022

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0 810	Continued From page 14 initial hire. During interview, LALD-A and DM-H stated that they thought training was provided annually to employees. A policy was requested, and two separate polices were provided. Review of the facility policy in the Emergency Preparedness Plan indicated that employees are trained at orientation and annually while review of the policy that was purchased from Care Providers stated that employees are trained at orientation and twice per year thereafter. Neither LALD-A or DM-H could verify which policy the licensee is currently following at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01290		

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01290	Continued From page 15	01290		

review, the licensee failed to ensure background studies were conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-F and ULP-I) with records reviewed. This had the potential to affect all residents currently receiving services. This resulted in an immediate correction order on September 9, 2022, at 10:44 a.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:

ULP-F
ULP-F had a hire date of July 20, 2022.

ULP-F's employee record included a Final Registry Results Form dated July 20, 2022, from the Minnesota Department of Human Services (DHS); however, lacked evidence of a background clearance as required.

On September 8, 2022, at approximately 11:16 a.m. ULP-F was observed to independently provide oral cares for R1 in her room.

ULP-I
ULP-I had a hire date of February 3, 2022.

ULP-I's employee record included a Notice of Background Study Disqualification letter dated March 10, 2022, from DHS. ULP-I's employee

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01290	Continued From page 16 record further included a Request for Reconsideration of Your Disqualification was Received letter dated April 11, 2022, from DHS; however, lacked evidence of a background clearance as required. On September 9, 2022, at 10:01 a.m. licensed assisted living director (LALD)-A confirmed ULP-F had not been cleared for her background study as she had not completed the fingerprinting process. LALD-A indicated the office manager tracked the background study process for employees, but this had been missed because ULP-F did not fill out the consent for background study in the auto-generated email. On September 9, 2022, at 11:34 a.m. LALD-A verified ULP-I had been working independently. LALD-A indicated there was a misunderstanding of what direct supervision meant and stated to his knowledge if working in the building with other staff then ULP-I could work independently. The licensee's 4.02 Background Studies policy dated August 1, 2021, included: No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [The licensee] will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by the surveyor's on-site observation and review by evaluation supervisor on September 9, 2022;	01290		

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01290	Continued From page 17 however, noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01470		

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01470	Continued From page 18 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (registered nurse (RN)-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	01470		

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01470	Continued From page 19 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: RN-C was hired on January 3, 2022, to provide direct care services to the licensee's residents. RN-C's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; On September 9, 2022, at 9:25 a.m. licensed assistant living director (LALD)-A verified RN-C had not completed any of the on-line EduCare training and may not have completed all the required components for the orientation to assisted living regulations. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of Oak Terrace providing	01470		

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01470	Continued From page 20 and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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	30836	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE NORTH MANKATO	1575 HOOVER DRIVE NORTH MANKATO, MN 56003

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01530	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (registered nurse (RN)-C) received the required amount of dementia care training in the required time frame. 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: The licensee provided services under an Assisted Living with Dementia Care license. RN-C was hired on January 3, 2022, to provide direct care services to the licensee's residents and provided oversight and supervision of nursing tasks. RN-C's employee record contained evidence the employee received two hours of dementia care training, not the required eight hours of training within 120 working hours of the employment start date as required. On September 9, 2022, at 9:25 a.m. licensed assistant living director (LALD)-A confirmed RN-C had not completed the required eight hours of dementia training within 120 hours of the	01530		

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01530	Continued From page 22 employment start date. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff will complete eight hours of initial training within 120 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 23 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of five residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R5's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R5's service plan dated August 4, 2021, indicated R5 received services which included bathing, dressing, grooming, blood sugar checks, and medication administration. R5's last two assessments were requested. Assessments dated March 15, 2022, and September 6, 2022, were provided (175 days from the previous assessment). On September 8, 2022, at 4:22 p.m. RN-C verified R5's assessments were greater than 90 days apart. RN-C stated the nurse assigned to	01620		

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01620	Continued From page 24 complete the assessments was no longer employed. RN-C indicated the licensee had since reassigned residents by floor that individual nurses were responsible for. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the RN would complete ongoing resident reassessments and monitoring as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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	30836	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE NORTH MANKATO	1575 HOOVER DRIVE NORTH MANKATO, MN 56003

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01640	Continued From page 25 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for three of five residents (R1, R2, and R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 On September 7, 2022, at 10:52 a.m. R1 was observed in her room resting in bed. A large urinary catheter storage bag was observed next to the bed placed in a wastebasket with a clean liner. On September 7, 2022, at approximately 11:45 a.m. unlicensed personnel (ULP)-H stated R1 had the catheter inserted approximately six months ago; about the same time she went on hospice services.	01640		

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01640	Continued From page 26 On September 8, 2022, at 11:16 a.m. ULP-F was observed providing catheter care for R1. R1's service plan dated January 31, 2022, identified R4 received medication management services, assistance with all activities of daily living, activities, laundry, and light housekeeping. The service plan failed to identify the treatment of catheter care assistance. R1's 90-day assessment dated August 12, 2022, indicated R1 had a catheter which required staff assistance with catheter care. On September 9, 2022, at 3:00 p.m. director of nursing (DON)-B confirmed R1 had the catheter placed by hospice several months ago but didn't know the exact date. DON-B further confirmed the service plan for R1 failed to identify staff assistance with catheter care and should have been updated so the current services would be reflected on the service plan. R2 R2's progress note by DON-B dated August 9, 2022, at 13:57 (1:57 p.m.) indicated: right hip wound: care manager cared for resident yesterday and stated not open and pink. Wound total 3 cm (centimeters) with 2 cm ruby colored and 1 cm open area. Cleansed and mepilex applied. Positioned on left side, heel protectors on. R2's physician order dated August 16, 2022, indicated: For right hip wound. Cleanse gently with wound cleanser or saline, pat dry, apply triad paste to wound bed, cover with foam dressing. Change every three days and prn (as needed) if loosened or soiled until resolved.	01640		

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01640	Continued From page 27 R2's service plan dated September 2 , 2022, identified R2 received medication management services, utilized alarms/WanderGuard, assistance with all activities of daily living, activities, laundry, and light housekeeping. The service plan failed to identify the recent wound care treatment. On September 9, 2022, at 3:00 p.m. DON-B confirmed R2's Service Plan was not revised when the resident developed a right hip wound and wound care treatment was initiated. R4 R4's service plan dated December 12, 2019, identified R4 received medication management services, ostomy care, assistance with bathing, dressing, grooming, laundry, and light housekeeping. The service plan failed to identify the treatment of TED (thrombo embolic deterrent) hose (compression socks used to increase circulation to prevent swelling) assistance. R4's prescriber order dated May 10, 2022, included an order for compression stockings in the a.m. as tolerated. R4's 90-day assessment dated June 28, 2022, identified R4 required assistance in the a.m./p.m. with TED (thrombo-embolic-deterrent) hose (stockings that help prevent blood clots and swelling in the legs). On September 8, 2022, at 9:15 a.m. R4 was observed wearing bilateral TED hose. On September 8, 2022, at 9:30 a.m. ULP-J stated	01640		

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01640	Continued From page 28 R4 wore TED hose daily and staff applied them for her. On September 8, 2022, at 10:02 a.m. registered nurse (RN)-K confirmed R4's service plan failed to identify the treatment of TED hose and should have been updated so the current services would be reflected on the service plan. The licensee's 6.08 Service Plans policy dated August 1, 2022, indicated all residents receiving assisted living services would have a service plan in place based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 29 (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 resident service plans included all the required content for five of five residents (R1, R2, R3, R4, and R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan dated January 31, 2022, identified R4 received medication management services, assistance with all activities of daily living, activities, laundry, and light housekeeping.	01650		

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01650	Continued From page 30 R1's service plan lacked the following: - 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 - a contingency plan that includes: - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2's service plan dated September 2, 2022, identified R2 received medication management services, utilized alarms/WanderGuard, assistance with all activities of daily living, activities, laundry, and light housekeeping. R2's service plan lacked the following: - a contingency plan that includes: - 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. R3 R2's service plan dated September 2, 2022, identified R2 received medication management services, utilized alarms/WanderGuard, assistance with all activities of daily living, activities, laundry, and light housekeeping. R3's service plan lacked the following: - a contingency plan that includes:	01650		

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01650	Continued From page 31 - 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. R4 R4's service plan dated December 12, 2019, indicated R4 received services which included bathing, dressing, grooming, ostomy cares, and medication administration. R4's service plan lacked the following: - a contingency plan that includes: - 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. R5 R5's service plan dated August 4, 2021, indicated R5 received services which included bathing, dressing, grooming, blood sugar checks, and medication administration. R5's service plan lacked the following: - a contingency plan that includes: - 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. On September 9, 2022, at 3:05 p.m. licensed assisted living director (LALD)-A and director of nursing (DON)-B verified the service agreement lacked the above required content. In addition,	01650		

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01650	Continued From page 32 LALD-A and DON-B stated the same format would be utilized for all residents. The licensee's 6.08 Service Plan policy dated August 1, 2021, identified a service plan would include a contingency plan with how the facility would support documented resident health care directive decisions, if any- including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others	01700		

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01700	Continued From page 33 who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of five residents (R3, R4, and R5) prior to providing medication management services, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 6, 2022, at approximately 1:08 p.m. director of nursing (DON)-B and licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to the residents receiving assisted living services. R3	01700		

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01700	Continued From page 34 R3's diagnoses included Parkinson's disease, dementia, and depression. R3's service plan dated December 29, 2021, identified R3 received services including medication administration. R3's prescriber orders dated February 8, 2022, included the following medications: one for Parkinson's disease, one for dementia, and one for depression. On September 7, 2022, at 11:37 a.m. the surveyor observed unlicensed personnel (ULP)-H administer R3's scheduled medication for Parkinson's disease. R3's record included a medication management assessment/plan form dated December 29, 2021, and reviewed July 8, 2022; however, the form lacked evidence the RN conducted a face-to-face review of all medications R3 was known to be taking to include risk of diversion and interventions to prevent diversion. On September 9, 2022, at 3:00 p.m. director of nursing (DON)-B verified R3's risk for diversion and interventions to prevent diversion was not identified on the medication assessment and management plan. R4 R4's diagnoses included macular degeneration (blurred or no vision in the center of the visual field) and mild cognitive impairment. R4's service plan dated December 12, 2019, identified R4 received services including medication administration.	01700		

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01700	Continued From page 35 R4's prescriber orders dated February 18, 2022, included the following medications: three for blood pressure, three vitamin/mineral supplements, and one lubricating eye drop. On September 7, 2022, at 11:02 a.m. the surveyor observed ULP-D administer R4's scheduled eye drop. R4's record included a medication management assessment/plan form dated February 24, 2021, and reviewed June 28, 2022; however, the form lacked evidence the RN conducted a face-to-face review of all medications R4 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R5 R5's diagnoses included diabetes, hypertension (high blood pressure), atrial fibrillation (irregular and often faster heartbeat) and hyperlipidemia (high cholesterol). R5's service plan dated August 4, 2021, identified R5 received services including medication administration. R5's prescriber orders dated February 22, 2022, included the following medications: one mild pain reliever, one heart supplement, two vitamin/mineral supplements, one for constipation, two diuretics, three for diabetes, two for blood pressure, one anticoagulant, one for prostrate, and one for cholesterol. On September 7, 2022, at 11:15 a.m. the surveyor observed ULP-E obtain R5's blood sugar reading and administer scheduled	01700		

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01700	Continued From page 36 medications. R5's record included a medication assessment and management plan form dated November 22, 2021, that was conducted face-to-face with the resident and/or resident representative. However, the form did not include review of all medications R5 was known to be taking to include indications for use, side effects, allergic or adverse reactions. On September 8, 2022, at 3:37 p.m. DON-B verified R4 and R5's record were missing the required components as noted above. DON-B stated the form had been updated but not all nurses were aware of checking the required components. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified prior to providing medication management services, a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. 1) The assessment must be conducted face-to-face with the resident by a registered nurse (RN). 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others	01700		

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01700	Continued From page 37 who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. **"diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [The Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01940 SS=E	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	01940		

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01940	Continued From page 38 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 have on the service plan a written statement of the treatment or therapy services provided for three of five (R1, R2 and R4) residents 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 6, 2022, at approximately 1:08 p.m. director of nursing (DON)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed.	01940		

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	30836	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE NORTH MANKATO	1575 HOOVER DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 39 R1 On September 7, 2022, at 10:52 a.m. R1 was observed resting in her room in bed. A large urinary catheter storage bag was observed next to the bed placed in an wastebasket with a clean liner. On September 7, 2022, at approximately 11:45 a.m. unlicensed personnel (ULP)-H stated R1 had the catheter inserted approximately six months ago; about the same time she went on hospice services. On September 8, 2022, at 11:16 a.m. ULP-F was observed providing catheter care for R1. R1's service plan dated January 31, 2022, identified R4 received medication management services, assistance with all activities of daily living, activities, laundry, and light housekeeping. The service plan failed to identify the treatment of catheter care assistance. R1's 90-day assessment dated August 12, 2022, indicated R1 had a catheter and required staff assistance with catheter care. On September 9, 2022, at 3:00 p.m. director of nursing (DON)-B confirmed R1 had the catheter placed by hospice several months ago but didn't know the exact date. DON-B further confirmed the service plan for R1 failed to identify staff assistance with catheter care and should have been updated so the current services would be reflected on the service plan. R2 R2's progress note by DON-B dated August 9, 2022, at 13:57 (1:57 p.m.) indicated: right hip wound: care manager cared for resident	01940		

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01940	Continued From page 40 yesterday and stated not open and pink. Wound total three cm (centimeters) with two cm ruby colored and one cm open area. Cleansed and mepilex applied. Positioned on left side, heel protectors on. R2's physician order dated August 16, 2022, indicated: For right hip wound. Cleanse gently with wound cleanser or saline, pat dry, apply triad paste to wound bed, cover with foam dressing. Change every three days and prn (as needed) if loosened or soiled until resolved. R2's service plan dated September 2, 2022, identified R2 received medication management services, utilized alarms/WanderGuard, assistance with all activities of daily living, activities, laundry, and light housekeeping. The service plan failed to identify the recent wound care treatment. On September 9, 2022, at 3:00 p.m. DON-B confirmed R2's Service Plan was not revised when the resident developed a right hip wound and wound care treatment was initiated. R4 R4's prescriber order dated May 10, 2022, included an order for compression stockings in the a.m. as tolerated. R4's 90-day assessment dated June 28, 2022, identified R4 required assistance in the a.m./p.m. with TED (thrombo-embolic deterrent) hose (compression socks used to increase circulation and reduce swelling in the legs). R4's service plan dated December 12, 2019,	01940		

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01940	Continued From page 41 identified R4 received medication management services, ostomy care, assistance with bathing, dressing, grooming, laundry, and light housekeeping. The service plan failed to identify the treatment of TED hose assistance. On September 8, 2022, at 9:15 a.m. R4 was observed wearing bilateral TED hose. On September 8, 2022, at 9:30 a.m. ULP-J stated R4 wore TED hose daily and staff applied them for her. On September 8, 2022, at 10:02 a.m. registered nurse (RN)-K confirmed the service plan for R4 failed to identify the treatment of TED hose. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, identified each resident at [The Licensee] receiving management of ordered or prescribed treatments, the facility would prepare and include in the service plan a written statement of the treatment that would be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the	02040		

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02040	Continued From page 42 property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability 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 September 8, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (LALD)-A and Director of Maintenance (DM)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated that licensee had had	02040		

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02040	Continued From page 43 meetings to discuss items for the HVA but did not have any documentation showing that this had been done or any mitigation factors had been developed for the hazards identified. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive	02170		

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02170	Continued From page 44 relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions for two of five residents (R5, R4) who received services under an assisted living with dementia care license, and failed to develop an individualized activity plan based on the evaluation, for five of five residents (R1, R2, R3, R4, and R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee held an assisted living with dementia care license, effective August 1, 2022. R5 R5's diagnoses included major depressive disorder, diabetes, hypertension (high blood pressure), atrial fibrillation (irregular and often	02170		

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02170	Continued From page 45 faster heartbeat) and hyperlipidemia (high cholesterol). On September 7, 2022, at 11:15 a.m. the surveyor observed unlicensed personnel (ULP)-E obtain R5's blood sugar reading and administer scheduled medications. R5's record contained a Resident Summary that identified R5 liked BINGO, music entertainers, and other afternoon activities; however, R5's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R4 R4's diagnoses included mild cognitive impairment and macular degeneration (blurred or no vision in the center of the visual field). On September 7, 2022, at 11:02 a.m. the surveyor observed ULP-D administer R4's scheduled eye drop. R4's record contained a Resident Profile document which reviewed the resident's previous address, career, schooling, family, food preferences, sleeping schedule, past and current interests. In addition, there was a Resident Summary that identified staff would need to go to R4's room and bring her to activities; however, R4's record lacked an evaluation of the following: - current abilities and skills - emotional and social needs and patterns;	02170		

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02170	Continued From page 46 - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R5 and R4's record lacked the development of an individualized activity plan. On September 9, 2022, at 8:40 a.m. licensed assisted living director (LALD)-A verified the missing components as noted above. LALD-A stated, "that's on me" and indicated he thought this was only a requirement of the locked dementia care unit. R1 R1's diagnoses included Alzheimer's disease, major depressive disorder, and delusional disorder. On September 8, 2022, at 11:16 a.m. ULP-F was observed providing catheter care for R1. R1's record contained a Resident Portrait completed by a family member on September 20, 2021. The Resident Portrait included historical information about R1 including past occupations, religious affiliation, food preferences, behaviors, and activity interests. R1's record contained a checklist dated November 16, 2021, which described the residents present condition related to physical abilities and limitations and adaptation necessary for the resident to participate. R1's record did include evidence an individualized	02170		

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02170	Continued From page 47 activity plan had been developed based on the Resident Portrait evaluation and the above checklist. R2 R2's diagnoses included Alzheimer's disease, mild cognitive impairment, and major depressive disorder. On September 8, 2022, 10:06 a.m. R2 was observed in the outside courtyard with several other residents and activity staff for the exercise and games activity. R2's record contained a Resident Portrait completed by a family member on September 6, 2021. The Resident Portrait included historical information about R2 including past occupations, religious affiliation, food preferences, behaviors, and activity interests. R2's record contained a checklist dated August 1, 2021, which described the residents present condition related to physical abilities and limitations and adaptation necessary for the resident to participate. R2's record did include evidence an individualized activity plan had been developed based on the Resident Portrait evaluation and the above checklist. R3 R3's diagnoses included Parkinson's disease, dementia, and depression. On September 8, 2022, at 2:10 p.m. R3 was observed in the recreation room participating in a music/sing-a-long activity.	02170		

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02170	Continued From page 48 R3's record contained a Resident Portrait completed by a family member on January 11, 2022. The Resident Portrait included historical information about R3 including past occupations, religious affiliation, food preferences, behaviors, and activity interests. R3's record contained a checklist dated January 5, 2022, which described the residents present condition related to physical abilities and limitations and adaptation necessary for the resident to participate. R3's record did include evidence an individualized activity plan had been developed based on the Resident Portrait evaluation and the above checklist. On September 9 2022, at 3:10 p.m. LALD-A confirmed R1, R2, and R3's record did not include an activity plan. The licensee's 3.05 ALDC (assisted living with dementia care) Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, included: 3. Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: -past and current interests -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behavioral intervention. 4. An individualized activity plan must be developed for each resident based on their	02170		

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02170	Continued From page 49 activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/06/22*
Time: 10:30:00
Report: 1033221131

Food and Beverage Establishment Inspection Report

Location:
Oak Terrace North Mankato
1575 Hoover Drive
North Mankato, MN56003
Nicollet County, 52

Establishment Info:
ID #: 0038868
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073872037
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.

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

3-302.11A(2) ** Priority 1 **

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

Raw poultry is stored above raw pork in the cooler. Employee removed the poultry and properly stored the raw animal foods in the cooler.

Corrected on Site

4-900 Protecting Clean Items

4-901.11

MN Rule 4626.0935 Allow equipment and utensils to air-dry after cleaning and sanitizing; only use cloths that are clean and dry for polishing utensils that have been air dried.

Facility is stacking wet dishes on the shelves and not letting them air dry before storing.

Comply By: 09/06/22

Surface and Equipment Sanitizers

Quaternary Ammonium: = 400 at Degrees Fahrenheit
Location: Red Bucket
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Type: Full
Date: *09/06/22*
Time: 10:30:00
Report: 1033221131
Oak Terrace North Mankato

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 157 Degrees Fahrenheit - Location: Mashed Potatoes-Steam Tables
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Chicken Tenders-Kitchen Cooler
Violation Issued: No

Process/Item: Cooling
Temperature: 72 Degrees Fahrenheit - Location: Sausage Links-Cooler
Violation Issued: No

Process/Item: Cooking
Temperature: 171 Degrees Fahrenheit - Location: Beef Roast-Oven
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Coleslaw-Cooler
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033221131 of 09/06/22.

Certified Food Protection Manager: Sheri L Dorn

Certification Number: FM1041 Expires: 03/30/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sheri L Dorn

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us