Electronically delivered

February 23, 2022

Administrator
Colony Court
200 22nd Avenue Northeast
Waseca, MN 56093

RE: Project Number(s) SL30450015

Dear Administrator:

On February 2, 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 November 18, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 18, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 18, 2021, found not corrected at the time of the February 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = $500.00

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

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

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

IMPOSITION OF FINES:

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

authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
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
	30450	A. BUILDING: _____ B. WING _____	R 02/02/2022

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are 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 # SL30450015-1 On January 31, 2022, through February 2, 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 November 18, 2021. At the time of the survey, there were 74 residents; 54 receiving services under the Assisted Living with Dementia Care 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.	
{0 430} SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services	{0 430}		

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{0 430}	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) with the required content for six of eight residents (R6, R5, R4, R2, R3, R9) with records reviewed. 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 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).	{0 430}		

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{0 430}	Continued From page 2 The findings include: R6, R5, R4, R2, R3 and R9's records lacked evidence of a UDALSA with the following required content: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract R6, R5, R4, R2, R3 and R9 began receiving assisted living services on August 1, 2021. R6 R6's Service Plan dated July 9, 2021, indicated R6 received services, which included dressing and medication administration. R6's record lacked evidence the UDALSA was received by R6. R5 R5's Service Plan dated September 11, 2020, indicated R5 received services, which included bathing, catheter care, dressing, blood glucose checks, and medication administration. R5's record lacked evidence the UDALSA was received by R5. R4 R4's Service Plan dated July 23, 2021, indicated R4 received services which included medication	{0 430}		

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{0 430}	Continued From page 3 administration and blood glucose checks. R4's record lacked evidence the UDALSA was received by R4. R2 R2's Service Plan dated July 6, 2021, indicated R2 received services, which included bathing, dressing, medication administration, and colostomy cares. R2's record lacked evidence the UDALSA was received by R2. R3 R3's Service Plan dated July 9, 2021, indicated R3 received services, which included dressing, medication administration, and blood glucose monitoring. R3's record lacked evidence the UDALSA was received by R3. R9 R9's Service Plan dated February 16, 2021, indicated R9 received services, which included medication administration and blood glucose monitoring. On February 2, 2022, at 8:55 a.m. licensed assisted living director (LALD)-A stated the UDALSA is an attachment in the contract and not all residents had received this yet. LALD-A indicated she had started at the beginning of the alphabet and operations manager (OM)-F had started at the end of the alphabet. LALD-A verified not all current residents had received the UDALSA, including the above-named residents. The licensee's Contract/UDALSA policy dated	{0 430}		

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{0 430}	Continued From page 4 October 25, 2021, noted the licensee will provide each resident on admission a contract and a Uniform Disclosure of Assisted Living Services and Amenities. No further information was provided.	{0 430}		
{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 according to the Minnesota Food Code. This had the potential to affect all 74 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 480}		

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{0 480}	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 2, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		
{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	{0 650}		

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{0 650}	Continued From page 6	{0 650}		

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:
Based on interview and record review, the licensee failed to ensure employee records included all required content for one of six employees licensed assisted living director (LALD-A), with employee 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:

LALD-A
LALD-A had a start date of July 27, 1992.

LALD-A's record lacked evidence of the following required content:
- documentation of annual performance reviews that identify areas of improvement needed and training needs.

On February 1, 2022, at approximately 9:10 a.m. LALD-A stated she had not had a performance

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{0 650}	Continued From page 7 review yet. Director of nursing (DON)-E indicated LALD-A's performance review was scheduled later this week. The licensee's Personnel Records policy revised October 11, 2021, noted a personnel file would be maintained for each paid employee and would include: - performance evaluations which identify areas of improvement needed and training needs [performance review must be conducted at least annually]. No further information was provided.	{0 650}		
{0 660} SS=E	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 interview and record review, the licensee failed to establish and maintain a	{0 660}		

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{0 660}	Continued From page 8 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, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for four of five employees, (unlicensed personnel (ULP)-O, ULP-H, ULP-M, and registered nurse (RN)-N) with records reviewed. In addition, the licensee failed to document a TST result in millimeters (mm) of induration for one of one employee (RN-N) with TST results 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 facility's TB risk assessment was completed July 20, 2021, and was determined to be a low risk level. ULP-O ULP-O began providing direct care services for the licensee on August 16, 2021. ULP-O's record lacked evidence of TB screening and testing had been completed upon hire. ULP-O had an undated TB history and symptom screen with documentation of a first step TST administered on January 17, 2022, and January	{0 660}		

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{0 660}	Continued From page 9	{0 660}		

26, 2022. No results of the TB skin test were documented.

On February 1, 2022, at 9:30 a.m. director of nursing (DON)-E stated the first step TST had been repeated because ULP-O had failed to have it read at appropriate time frame. DON-E verified ULP-O was working without a TST and confirmed the TB history and symptom screen was undated, indicating it was most likely done on January 17, 2022, with the first TST.

ULP-H
ULP-H began providing direct care services for the licensee on August 22, 2017.

ULP-H's record lacked evidence of TB screening and testing had been completed upon hire. TB history and symptom screen date was illegible but was dated as year 2018. A chest x-ray in the employee file was dated May 11, 2011, (six years prior to ULP-H's hire date at facility). On February 1, 2022, at 12:00 p.m. DON-E stated it should have been completed upon hire and was not sure how to correct at this point. DON-E verified no TB screening or testing had been completed for ULP-H yet.

ULP-M
ULP-M began providing direct care service for the licensee on January 3, 2022.

ULP-M's record lacked evidence of TB testing completed upon hire. A TB history and symptom screen had been completed on January 3, 2022; however, no TST had been completed.

On February 1, 2022, at 9:39 a.m. DON-E verified ULP-M had been working without a TST until the file had been requested by the surveyor on

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{0 660}	Continued From page 10 January 31, 2022. RN-N RN-N was hired on December 22, 2021, to provide nursing services for the licensee. RN-N's employee file lacked evidence of TB testing completed upon hire. A TB history and symptom screen had been completed on December 22, 2021, and first step TST administered. The first step TST was read on December 24, 2021, and documented as "negative;" however, it was not read in mm of induration. No second step TST had been completed. On February 1, 2022, at 9:32 a.m. DON-E verified the first step TST had not been documented in mm of induration and no second step TST was completed. The licensee's TB Prevention and Control policy revised September 20, 2021, noted at time of hire and prior to any contact with clients, all assisted living employees and all volunteers will be screened for Tuberculosis including TB symptoms and given a two-step skin test or single interferon gamma release assay (IGRA). TST documentation will include the date of the test, the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). No further information was provided.	{0 660}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	{0 780}		

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{0 780}	Continued From page 11 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	{0 810}		

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{0 810}	Continued From page 12 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30450	A. BUILDING: _____ B. WING _____	R 02/02/2022

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{0 900}	Continued From page 13 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract prior to providing assisted living services for six of eight residents (R4, R5, R6, R2, R3, R9) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 900}		

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{0 900}	Continued From page 14 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: R4, R5, R6, R2, R3, and R9 all began receiving assisted living services on August 1, 2021, and their records lacked evidence of a written assisted living contract prior to providing assisted living services as required. R4 R4's Service Plan dated July 23, 2021, indicated R4 received services which included medication administration and blood glucose checks. R4's record lacked evidence an assisted living contract was received by R4. R5 R5's Service Plan dated September 11, 2020, indicated R5 received services which included bathing, catheter care, dressing, blood glucose checks, and medication administration. R5's record lacked evidence an assisted living contract was received by R5. R6 R6's Service Plan dated July 9, 2021, indicated R6 received services which included dressing and medication administration. R6's record lacked evidence an assisted living contract was received by R6.	{0 900}		

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{0 900}	Continued From page 15 R2 R2's Service Plan dated July 6, 2021, indicated R2 received services, which included bathing, dressing, medication administration, and colostomy cares. R2's record lacked evidence an assisted living contract was received by R2. R3 R3's Service Plan dated July 9, 2021, indicated R3 received services, which included dressing, medication administration, and blood glucose monitoring. R3's record lacked evidence an assisted living contract was received by R3. R9 R9's Service Plan dated February 16, 2021, indicated R9 received services, which included medication administration and blood glucose monitoring. R9's record lacked evidence an assisted living contract was received by R9. During the entrance conference on January 31, 2022, at 10:20 a.m. licensed assisted living director (LALD)-A indicated the contract was completed but had not been executed with all residents yet. On February 2, 2022, at 8:55 a.m. LALD-A indicated the licensee had been working towards getting all contracts signed by residents; however, LALD-A confirmed not all current residents had received the contract, including the above-named residents.	{0 900}		

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{0 900}	Continued From page 16 The licensee's Contract/UDALSA policy dated October 25, 2021, noted the licensee will provide each resident on admission a contract and a Uniform Disclosure of Assisted Living Services and Amenities. No further information was provided.	{0 900}		
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of six employees providing services (unlicensed personnel (ULP)-H and ULP-O) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents 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	{01460}		

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{01460}	Continued From page 17 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H and ULP-O's records lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. ULP-H ULP-H had a start date of August 1, 2021, under the assisted living with dementia care license. ULP-O ULP-O had a start date of August 16, 2021, under the assisted living with dementia care license. On February 1, 2022, at 3:27 p.m. director of nursing (DON)-E stated all annual training was completed with their online Educare modules. DON-E verified ULP-H and ULP-O's transcripts did not include orientation to assisted living facility licensing requirements training. The licensee's Assisted Living and Assisted Living with Memory Care Orientation- All Staff policy revised October 8, 2021, noted employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following topics: - An overview of Minnesota's assisted living law - An introduction and review of agency policies and procedures related to the provision of assisted living services. - Emergency and disaster training - Employee Right to Know -The assisted living bill of rights and staff responsibilities to ensuring the exercise and	{01460}		

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{01460}	Continued From page 18 protection of those rights. - Infection control - HIPAA/ Privacy Practice - Employee job description - Organizational chart and roles of staff within the facility - Principles of person-centered planning and service delivery and how they apply to direct support services -Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure - Maltreatment of vulnerable adults - How to report maltreatment of vulnerable adults - How to report a crime - Complaint process No further information was provided.	{01460}		
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	{01540}		

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{01540}	Continued From page 19	{01540}		

hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for one of six employees (unlicensed personnel (ULP)-M), 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:

The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2021.

ULP-M began providing assisted living services to residents on January 3, 2022.

ULP-M did not have documentation of completing the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-M's start date. A review of the working schedule verified ULP-M was over 80 working hours of the employment start date.

On February 2, 2022, at 10:38 a.m. director of nursing (DON)-E confirmed ULP-M had worked over 80 hours since her hire date and ULP-M's

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{01540}	Continued From page 20 employee records only included 6.75 hours of training. DON-E indicated there had been an error when assigning the dementia care modules for ULP-M. The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy revised October 8, 2021, noted direct-care employees would complete a minimum of 8 hours initial training on dementia care topics within 80 working hours of the employment start date. No further information was provided.	{01540}		
{01620} SS=D	144G.70 Subd. 2 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	{01620}		

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{01620}	Continued From page 21 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of five residents (R6) as required 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: R6's diagnoses included diabetes mellitus and hypertension (high blood pressure). R6's Service Plan dated July 9, 2021, indicated R6 received services including dressing and medication administration. R6's last two assessments were requested. 90-day assessments dated August 26, 2021, and December 6, 2021, were provided. The December 6, 2021, assessment was 102 days after the previous assessment (12 days late). On February 1, 2021, at 10:49 a.m. registered nurse (RN)-C verified R6's assessment had been completed late. RN-C indicated she had counted the days incorrectly for due date when the	{01620}		

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{01620}	Continued From page 22 licensee had changed software programs. The facility's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy revised October 11, 2021, indicated the RN would reassess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. The RN will reassess the resident if the resident has a change in condition. No further information was provided.	{01620}		
{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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration and follow through for one of four residents (R11) reviewed who received treatments.	{01960}		

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{01960}	Continued From page 23	{01960}		

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:

R11's diagnoses included chronic obstructive pulmonary disease (persistent respiratory symptoms like progressive breathlessness and cough.), heart failure (heart disease causing fatigue and shortness of breath), and hypertension (high blood pressure).

R11's Service Plan dated February 2, 2022, indicated R11 received services, which included bathing, dressing, grooming, and medication administration.

R11's prescriber orders dated December 30, 2021, included an order for daily weights; notify provider if weight continues to increase by 3-4 pounds (lbs.); weight gain greater than 3 lbs. in 3 days or 5 lbs. in 1 week.

R11's documented task services from January 19, 2022, through February 1, 2022, included daily weights; however, it lacked documentation that the nurse and/or provider was notified when R11 had weight gains of 3 lbs. in 3 days or 5 lbs. in 1 week. R11 had a 12.7 lb. weight gain in the 14 day look back period.
January 19, 2022, = 261.8 lbs.
January 20, 2022, = 261.8 lbs.
January 21, 2022, = 258.6 lbs.

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{01960}	Continued From page 24	{01960}		

January 22, 2022, = 264.8 lbs. (+6.2 lbs.)
January 23, 2022, = 267.2 lbs. (+2.4 lbs.)
January 24, 2022, = 270.4 lbs. (+3.2 lbs.)
January 25, 2022, = 270.4 lbs.
January 26, 2022, = 267.6 lbs. (-2.8 lbs.)
January 27, 2022, = 272.0 lbs. (+4.4 lbs.)
January 28, 2022, = 270.6 lbs. (-1.4 lbs.)
January 29, 2022, = 271.3 lbs. (+0.7 lbs.)
January 30, 2022, = no weight documented
January 31, 2022, = 273.2 lbs. (+1.9 lbs.)
February 1, 2022, = 274.5 lbs. (+1.3 lbs.)

On February 2, 2022, at 11:32 a.m. registered nurse (RN)-C stated she was unaware of R11's weight gain. RN-C stated R11's weight gain should have been reported to her so she could have reported R11's weight gain to the physician as ordered. RN-C confirmed this was lacking in R5's record.

The licensee's Documentation of Medication, Treatment and Therapy Management Services revised October 4, 2021, indicated staff will document each task immediately after that task has been performed.

The licensee's Individualized Treatment and Therapy Management Plan policy dated October 21, 2021, indicated staff will provide ordered or prescribed treatment and therapy services including any resident-specific requirement 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.

No further information was provided.

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{02040}	Continued From page 25	{02040}		
{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 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: No further action required.	{02040}		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *02/02/22*
Time: 08:47:20
Report: 8044221033

Food and Beverage Establishment Inspection Report

Location:
Colony Court
200 22nd Ave NE
Waseca, MN56093
Waseca County, 81

Establishment Info:
ID #: 0038264
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078376100
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 previously issued on 11/16/21 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

2/2/22: Reissued. A state of Minnesota certicate is required in to the course certificate.

Application was recently submitted.

Issued on: 11/16/21 *Comply By: 12/16/21*

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: Sliders in WIC
Violation Issued: No

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

Type: Follow-Up
Date: *02/02/22*
Time: 08:47:20
Report: 8044221033
Colony Court

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 Department of Health inspection report number 8044221033 of 02/02/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Karen

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us

Electronically Delivered

December 27, 2021

Administrator
Colony Court
200 22nd Avenue Northeast
Waseca, MN 56093

RE: Project Number(s) SL30450015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 18, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program $500.00.

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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.

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

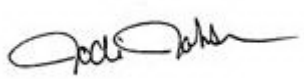
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



Jodi Johnson, Supervisor
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State Evaluation Team
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Telephone: 507-696-2437 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
	30450	A. BUILDING: _____ B. WING _____	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS 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: Project #SL30450015 On November 15, 2021 through November 18, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 71 residents receiving services under the Assisted Living with Dementia Care License.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to meet the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures as required 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 15, 2021, at approximately 11:20 a.m. licensed assisted living director (LALD)-A confirmed she was responsible for and participated in the day-to-day operations. LALD-A stated they were familiar with the current Assisted Living with Dementia Care licensing rules and regulations.	0 250		

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0 250	Continued From page 3 The licensee attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: The facility failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management. Refer to licensing order at Statute 144G.41 Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 when two of three dietary staff (DS-I and DS-J) failed to wear the appropriate personal protective equipment (PPE).	0 250		

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0 250	Continued From page 4 Refer to licensing order at Statute 144G.42 Subd. 9. The licensee failed to establish and 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, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for three of four employees (unlicensed personnel (ULP)-B, ULP-H, and registered nurse (RN)-D). Refer to licensing order at Statute 144G.60, Subd. 1. The licensee failed to ensure a background study had been completed prior to providing services for one of four employees (ULP-B). Refer to licensing order at Statute 144G.61, Subd. 1. The licensee failed to ensure training and competency evaluations of ULP providing assisted living services were conducted by a RN for one of two ULP (ULP-B). Refer to licensing order at 144G.61, Subd. 2 (a and b). The licensee failed to ensure training and competency evaluations contained all the required training, prior to providing direct care for one of two unlicensed personnel (ULP-H). Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure four of four employees providing services (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-B, ULP-H, and registered nurse (RN)-D) completed an orientation to assisted living facility licensing requirements and regulations before	0 250		

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0 250	Continued From page 5 providing services to residents. Refer to licensing order at Statute 144G.64 (a). The licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for four of four employees (ULP-B, licensed assisted living director (LALD)-A, RN-D, and ULP-H). Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure the RN completed a change in condition assessment when required for one of one resident (R6). In addition, the RN failed to conduct a reassessment not to exceed 90 days for one of one residents (R4). Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure time sensitive medications were labeled with the date open for three of three residents (R7, R3, R8) and failed to ensure medications were maintained bearing the original prescription label with legible information for two of two residents (R7, R9) with medication storage reviewed. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed upon disposition, document in the resident's record the disposition of the medication including the medication's prescription number as applicable for one of one discharged resident (R1). Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop and implement a treatment or therapy management plan to include all required content for four of four residents (R5, R4, R2, R3). Refer to licensing order at Statute 144G.72,	0 250		

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0 250	Continued From page 6 Subd. 4. The licensee failed to ensure the RN specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for four of four residents (R5, R4, R2, R3). Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to document treatment administration for two of four residents (R5 and R4) reviewed who received treatments. Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of four residents (R3) receiving treatments. Refer to licensing order at Statute 144G.83, Subd. 3. The licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. Twenty-six (26) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted	0 430		

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0 430	Continued From page 7 living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) with the required content for five of five residents (R6, R5, R4, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R6, R5, R4, R2, and R3's records lacked evidence of a UDALSA with the following required	0 430		

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0 430	Continued From page 8 content: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract R6, R5, R4, R2, and R3 began receiving assisted living services on August 1, 2021. R6 R6's Service Plan dated July 9, 2021, indicated R6 received services, which included dressing and medication administration. On November 15, 2021, at approximately 11:50 a.m. R6 was observed wearing a left arm sling and ambulate using a hemi-walker. At this time, unlicensed personnel (ULP)-B stated she had assisted R6 with a shower in the morning. R6's record lacked evidence the UDALSA was received by R6. R5 R5's Service Plan dated September 11, 2020, indicated R5 received services, which included bathing, catheter care, dressing, blood glucose checks, and medication administration. On November 16, 2021, at approximately 11:43 a.m. ULP-B was observed to administer R5 an eye drop.	0 430		

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0 430	Continued From page 9 R5's record lacked evidence the UDALSA was received by R5. R4 R4's Service Plan dated July 23, 2021, indicated R4 received services which included medication administration and blood glucose checks. On November 17, 2021, at approximately 10:00 a.m. R4 stated staff administered his medications and completed his blood sugar checks. R4's record lacked evidence the UDALSA was received by R4. R2 R2's Service Plan dated July 6, 2021, indicated R2 received services, which included dressing, medication administration, and colostomy cares. On November 17, 2021, at 2:18 p.m. ULP-H was observed providing colostomy cares for R2. R2's record lacked evidence the UDALSA was received by R2. R3 R3's Service Plan dated July 9, 2021, indicated R2 received services, which included dressing, medication administration, and .blood glucose monitoring. On November 16, 2021, at 11:13 a.m. ULP-H was observed to check R3's blood glucose and administer insulin to him.	0 430		

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0 430	Continued From page 10 R3's record lacked evidence the UDALSA was received by R3. On November 16, 2021, at 1:34 p.m. licensed assisted living director (LALD)-A verified none of the current residents had received a UDALSA. LALD-A indicated the UDALSA was part of the updated contract that was still being finalized, and once that was completed the residents would receive at that time. A facility policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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 11 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 had the potential to affect all 71 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 16, 2021, for the specific Minnesota Food Code deficiencies. 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	0 510		

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0 510	Continued From page 12	0 510		

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 to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 when two of three dietary staff (DS-I and DS-J) failed to wear the appropriate personal protective equipment (PPE).

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 failed to ensure employees were wearing appropriate PPE as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines.

On November 16, 2021, at 10:25 a.m. DS-I and DS-J were observed in the kitchen area without face masks on. When interviewed at this time, DS-I stated no PPE was required in the kitchen unless they were within 6 feet of a resident. DS-K

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0 510	Continued From page 13 was setting tables in the dining room area wearing mask and goggles. DS-K also confirmed PPE was not required for staff in the kitchen area, only if out in the dining room where resident contact was possible. On November 17, 2021, at 10:19 a.m. DS-I and DS-J were observed in the kitchen at the prep table together. Both employees were within 6 feet of each other; however, no face mask was worn by either employee. On November 17, 2021, at 11:45 a.m. director of nursing (DON)-E stated all staff should be wearing a medical grade face mask when working unless sitting at a desk by themselves or eating. DON-E verified this would include dietary staff working in the kitchen. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well fitting facemask. The licensee's policy's lacked instruction on PPE use for COVID-19. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 650	Continued From page 14	0 650		
0 650 SS=E	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, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for four of four employees (unlicensed personnel (ULP)-B,	0 650		

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0 650	Continued From page 15 licensed assisted living director (LALD)-A, ULP-H, and registered nurse (RN)-D) with employee 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: ULP-B ULP-B began providing direct care services for the licensee on October 27, 2021. ULP-B lacked a current employee record. On November 16, 2021, at 11:30 a.m. ULP-B was observed to administer insulin to R9. On November 18, 2021, at approximately 12:00 p.m. the licensed assisted living director (LALD)-A stated ULP-B had been an employee for the licensee previously, and was a current employee at their "sister" facility. The LALD-A indicated due to staffing shortages they had asked ULP-B to work at this facility. On November 18, 2021, at 1:30 p.m. LALD-A and director of nursing (DON)-E verified there was no current employee record for ULP-B. LALD-A	0 650		

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0 650	Continued From page 16 LALD-A had a start date of July 27, 1992. LALD-A's record lacked evidence of the following required content: - evidence of current registration or certification; - documentation of annual performance reviews that identify areas of improvement needed and training needs; and - current job description to include qualifications. On November 18, 2021, at approximately 10:04 a.m. LALD-A stated she had not had a performance review since 2017, and verified her employee file lacked the required content as noted above. LALD-A was able to produce a copy of her LALD license with expiration date of October 31, 2022, but verified a copy had not been available in the employee file as required. ULP-H ULP-H began providing direct care services for the licensee on August 22, 2017. ULP-H was an active certified nursing assistant (CNA) upon hire; however, the nursing assistant certification expired on January 26, 2021. ULP-H's record lacked evidence of the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-H's most recent annual performance evaluation was dated August 22, 2020; and - required annual training and competency evaluations November 18, 2021, at 2:20 p.m. LALD-A stated that if the required competencies were not in the employee file, then they had not been completed.	0 650		

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0 650	Continued From page 17 LALD-A further indicated ULP-H was a CNA upon hire, and she was unaware ULP-H had not maintained the certification. RN- D RN-D was hired on August 5, 2021, to provide nursing services for the licensee. RN-D's employee file lacked evidence of the following required content: - current job description; and - verification that TB screening and testing was completed upon hire. On November 18, 2021, at 3:00 p.m. LALD-A confirmed a job description was not in RN-D's employee file. TB screening and testing had been completed, but she was unable to locate the form. The licensee's Personal Records policy revised October 11, 2021, noted a personnel file will be maintained for each paid employee, all regularly scheduled volunteers providing services, and each individual contractor of the facility providing services. The personnel records for each employee would include: - evidence of current professional licensure, registration or certificate, if required by the law or other state requirements; - record of orientation; - record of required in-service education for all staff providing services to residents, including annual trainings and infection control training; - documentation of a completed background study; - documentation that the employee is not on the OIG or MHCP exclusion list; - TB screening results;	0 650		

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0 650	Continued From page 18 - results of supervision observations; - performance evaluations which identify areas of improvement needed and training needs [performance review must be conducted at least annually]; -current job description, which includes qualifications, responsibilities, and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=E	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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on	0 660		

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0 660	Continued From page 19 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, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for three of four employees, (unlicensed personnel (ULP)-B, ULP-H, and registered nurse (RN)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 facility's TB risk assessment was completed July 20, 2021, and was determined to be a low risk level. ULP-B started to provide direct care to residents on October 27, 2021. ULP-B lacked an employee record to include evidence ULP-B had a current TB screening or TST prior to providing direct care to residents. On November 18, 2021, at 1:30 p.m. LALD-A and director of nursing (DON)-E verified there was no current employee record for ULP-B, and no documentation of a two step screening for active/latent TB. ULP-H ULP-H began providing direct care services for the licensee on August 22, 2017.	0 660		

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0 660	Continued From page 20 ULP-H's record lacked evidence of TB screening and testing had been completed upon hire. TB history and symptom screen date was illegible, but was dated as year 2018. A chest x-ray in the employee file was dated May 11, 2011. On November 18, 2021, at 11:20 a.m. director of nursing (DON) stated it should have been completed upon hire. RN-D RN-D was hired on August 5, 2021, to provide nursing services for the licensee. RN-D's employee file lacked evidence of TB screening and testing had been completed upon hire. RN-D's employee file also lacked evidence of TB training upon hire. On November 18, 2021, at 3:00 p.m. LALD-A stated TB screening and testing had been completed, but she was unable to locate the form. The facility's TB Prevention and Control policy revised September 20, 2021, noted at time of hire and prior to any contact with clients, all assisted living employees and all volunteers will be screened for Tuberculosis including TB symptoms and given a two-step skin test or single interferon gamma release assay (IGRA). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 21	0 680		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. In addition the facility failed to post emergency exit diagrams. This had the potential to affect all residents, staff and visitors.	0 680		

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0 680	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 15, 2021, at approximately 11:20 a.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was requested. During tour of the facility on November 15, 2021, at approximately 12:20 p.m. there was no observed signage posted or information regarding the licensee's emergency plan or emergency exit diagrams at the facility entrance, in the hallways, in the dining area or in the living areas. On November 18, 2021, at 10:10 a.m. director of nursing (DON)-E stated the emergency preparedness policies had been started, but were not completed. The facility risk assessment was not comprehensive and did not include information regarding the resident population at the facility. DON-E confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z which included: - a written emergency disaster plan that contained 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; - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all	0 680		

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0 680	Continued From page 23 residents; - post emergency exit diagrams on each floor; - emergency and disaster training to all staff during the initial staff orientation; and - Appendix Z required elements The licensee's Emergency and Disaster Preparedness policy dated October 26, 2021, indicated the facility would have completed a hazard vulnerability assessment (HVA). Based on the HVA, an Emergency Preparedness Plan has been developed and would address the following requirements: - it is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. - includes strategies for addressing emergency events identified by the risk assessment. - addresses our resident population, including, but not limited to, persons at-risk; the type of services [the facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. - includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. - the emergency disaster plan contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. written plan of action in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. - a written communication plan. - [the facility] has developed and implements	0 680		

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0 680	Continued From page 24 emergency preparedness policies - a written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. - the facility will post the emergency disaster plan prominently. - the facility provides building emergency exit diagrams to all residents. - emergency exit diagrams are posted on each floor. - training and exercises - the facility provides training in emergency and disaster preparedness policies and procedures to all staff during the initial staff orientation and annually thereafter and makes 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. - training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles. - the facility conducts exercises to test the Emergency Preparedness Plan at least twice per year. the emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 25 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms and failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate as required by MN Statute 144G.45 subd. 2(a)(1). 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	0 780		

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COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

(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
0 780	Continued From page 26 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On facility tour with the Maintenance Supervisor (MS)-G between approximately 9:10 a.m. and 10:55 a.m. on November 17, 2021, it was observed that all the resident units in the 400 wing had smoke alarms in the living room area but were not provided with smoke alarms in the sleeping rooms. An interview conducted with MS-G indicated that the limited number of resident units in the 400 wing were the only ones in the facility that had separate sleeping and living rooms requiring multiple smoke alarms. This deficient condition was visually verified by the MS-G accompanying on the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 27 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 interview and record review, the licensee failed to provide fire safety and evacuation training at least twice per year after hire to employees and failed to require evacuation drills twice per year per shift with at least one evacuation drill every other month, as required by MN Statute 144G.45 Subd. 2 (c) and (f). This deficient practice had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident 's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 28 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 resident s). The findings include: On November 9, 2021, between approximately 8:25 a.m. and 9:10 a.m. a record review and interview were conducted with the Maintenance Supervisor (MS)-G and licensed assisted living director (LALD)-A on employee training of the fire safety and evacuation plans for the facility and facility evacuation drills. Based on this record review, the licensee did not have record of providing employees with fire safety and evacuation training at least twice per year after hire. An interview conducted with MS-G and LALD-A indicated that employees are trained at hire and annually thereafter. A record review and interview were also conducted with MS-G and LALD-A on evacuation drills for the facility. Based on this record review, the licensee did not have documentation indicating that they had conducted any evacuation drills. An interview conducted with MS-G and LALD-A indicated the licensee had only been conducting fire drills instead of evacuation drills for employees, had ceased doing so with the onset of COVID, and had not resumed at the time of survey. Due to being fully sprinkled, fire drills for this facility were shelter in place drills and did not encompass the evacuation drill requirements. A policy was requested on the fire safety and evacuation training to verify compliance with MN Statute 144G.45 subd. 2(c), but was not provided.	0 810		

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0 810	Continued From page 29 A policy was requested on the facility evacuation drills, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	0 900		

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0 900	Continued From page 30 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written assisted living contract prior to providing assisted living services for five of five residents (R4, R5, R6, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4, R5, R6, R2, and R3 all began receiving assisted living services on August 1, 2021, and their records lacked evidence of a written assisted living contract prior to providing assisted living services as required. R4 R4's Service Plan dated July 23, 2021, indicated R4 received services which included medication administration and blood glucose checks. On November 17, 2021, at approximately 10:00	0 900		

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0 900	Continued From page 31 a.m. R4 stated staff administered his medications and completed his blood sugar checks. R4's record lacked evidence an assisted living contract was received by R4. R5 R5's Service Plan dated September 11, 2020, indicated R5 received services which included bathing, catheter care, dressing, blood glucose checks, and medication administration. On November 16, 2021, at approximately 11:43 a.m. unlicensed personnel (ULP)-B was observed to administer R5 an eye drop. R5's record lacked evidence an assisted living contract was received by R5. R6 R6's Service Plan dated July 9, 2021, indicated R6 received services which included dressing and medication administration. On November 15, 2021, at approximately 11:50 a.m. R6 was observed to ambulate using a hemi-walker and seat herself at a table in the west wing dining room for lunch. ULP-B stated she had assisted R6 with a shower in the morning. R6's record lacked evidence an assisted living contract was received by R6. R2 R2's Service Plan dated July 6, 2021, indicated R2 received services which included dressing, medication administration, and colostomy cares. On November 17, 2021, at 2:18 p.m. ULP-H was	0 900		

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0 900	Continued From page 32 observed providing colostomy cares for R2. R2's record lacked evidence an assisted living contract was received by R2. R3 R3's Service Plan dated July 9, 2021, indicated R2 received services which included dressing, medication administration, and .blood glucose monitoring. On November 16, 2021, at 11:13 a.m. ULP-H was observed to check R3's blood glucose and administer insulin to R3. R3's record lacked evidence an assisted living contract was received by R3. On November 18, 2021, at 9:19 a.m. DON-E stated there was not a policy for an assisted living contract. On November 16, 2021, at 1:34 p.m. licensed assisted living director (LALD)-A verified none of the current residents had received an assisted living contract as it was still being updated and had not been finalized by management yet. LALD-A stated all the residents would receive the contract once it was completed. A facility policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=D	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 33 (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 review, the licensee failed to ensure a background study had been completed prior to providing services for one of four employees (unlicensed personnel (ULP)-B) with records reviewed. This resulted in an immediate correction order on November 18, 2021, at approximately 1:30 p.m. 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-B began providing direct care services for	01290		

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01290	Continued From page 34 the licensee on October 27, 2021. The licensee lacked evidence a background study had been completed prior to ULP-B providing direct care services. On November 16, 2021, at 11:30 a.m. ULP-B was observed to administer insulin to R9. On November 18, 2021, at approximately 12:00 p.m. licensed assisted living director (LALD)-A stated ULP-B had been an employee for the licensee previously, and was a current employee at their "sister" facility. LALD-A indicated due to staffing shortages they had asked ULP-B to work at this facility. On November 18, 2021, at 12:30 p.m. LALD-A verified ULP-B provided unsupervised direct cares for residents in the facility. On November 18, 2021, at 1:30 p.m. LALD-A and director of nursing (DON)-E verified there was no current employee record for ULP-B, and they had not conducted a background study prior ULP-B providing direct care services. The licensee's Background Checks policy revised October 11, 2021, identified all employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. "Direct contact" means providing face-to face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Immediately	01290		

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01290	Continued From page 35 On November 18, 2021, at approximately 4:00 p.m. the immediacy was removed by evidence provided to MDH surveyors and supervisor of cleared background study for ULP-B.	01290		
01360 SS=D	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) for one of two unlicensed personnel (ULP-B) 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	01360		

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01360	Continued From page 36	01360		

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-B began providing direct care services for the licensee on October 27, 2021.

On November 16, 2021, at 11:30 a.m. ULP-B was observed to administer insulin to R9.

On November 18, 2021, at approximately 12:00 p.m. licensed assisted living director (LALD)-A stated ULP-B had been an employee for the licensee previously, and was a current employee at their "sister" facility. LALD-A indicated due to staffing shortages they had asked ULP-B to work at this facility.

ULP-B lacked an employee record with evidence the employee had been trained by a RN in the following areas:
- documentation requirements for all services provided;
- reports of changes in the resident's condition to the supervisor designated by the facility;
- basic infection control including blood-borne pathogens;
- maintenance of a clean and safe environment;
- appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting;
- training on the prevention of falls;
- standby assistance techniques and how to perform them;
- medication, exercise, and treatment reminders;
- basic nutrition, meal preparation, food safety,

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01360	Continued From page 37 and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; awareness of confidentiality and privacy; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On November 18, 2021, at approximately 11:47 a.m. director of nursing (DON)-E stated ULP-B may have competency documented at "sister" facility, but not here. DON-E further stated "not documented not done" and confirmed there was no employee file for ULP-B that would include the above training or verification the training had been completed by a RN.	01360		

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01360	Continued From page 38 The facility's Assisted Living Orientation-ULP Staff policy revised October 8, 2021, noted: Training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. A newly hired staff person hired by a licensed assisted living facility may satisfy the following training requirements by providing written proof of previously completed training within the past 18 months. An evaluation of competency for accepted documentation of training in the past 18 months will be completed before the staff person provides assistance to residents. The RN onsite will observe and sign-off the newly hired staff member on the tasks prior to them providing care to residents on their own. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	01370		

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01370	Continued From page 39 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations contained all the required training, prior to providing direct care for one of two unlicensed personnel (ULP-H) 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	01370		

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01370	Continued From page 40 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-H began providing direct care services for the licensee under the comprehensive license on August 22, 2017. ULP-H was an active certified nursing assistant (CNA) upon hire; however, the nursing assistant certification expired on January 26, 2021. On November 16, 2021, at 9:02 a.m. ULP-H was observed administering medications to R3, R7, and R8. ULP-H's record lacked evidence of the following education and/or competencies had been completed: - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; and	01370		

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01370	Continued From page 41 - awareness of commonly used health technology equipment and assistive devices November 18, 2021, at 2:20 p.m. LALD-A stated that if the required competencies were not in the employee file, then they had not been completed. LALD-A further indicated being unaware ULP-H had not maintained the nursing assistant certification. The facility's Assisted Living Orientation-ULP Staff policy revised October 8, 2021, noted: Training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. A newly hired staff person hired by a licensed assisted living facility may satisfy the following training requirements by providing written proof of previously completed training within the past 18 months. An evaluation of competency for accepted documentation of training in the past 18 months will be completed before the staff person provides assistance to residents. The RN onsite will observe and sign-off the newly hired staff member on the tasks prior to them providing care to residents on their own. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 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:	01380		

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01380	Continued From page 42 (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 observation, interview, and record review the licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed personnel (ULP-H) 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: ULP-H's employee record lacked evidence of demonstrated competency in all the required topics. ULP-H began providing direct care services for	01380		

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01380	Continued From page 43	01380		

the licensee under the comprehensive license on August 22, 2017. ULP-H was an active certified nursing assistant (CNA) upon hire; however, the nursing assistant certification expired on January 26, 2021.

On November 16, 2021, at 9:02 a.m., ULP-H was observed administering medications to R3, R7, and R8.

ULP-H's record lacked evidence of the following education and/or competencies had been completed:
- observing, reporting, and documenting resident status;
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
- reading and recording temperature, pulse, and respirations of the resident;
- recognizing physical, emotional, cognitive, and developmental needs of the resident;
- safe transfer techniques and ambulation;
- range of motioning and positioning; and
- administering medications or treatments as required.

On November 18, 2021, at 2:20 p.m. LALD-A stated that if the required competencies were not in the employee file, then they had not been completed. LALD-A indicated being unaware ULP-H had not maintained the nursing assistant certification.

The facility's Assisted Living Orientation-ULP Staff policy revised October 8, 2021, noted: training and competency evaluations of unlicensed personnel providing assisted living

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01380	Continued From page 44 services will be completed by a registered nurse. A newly hired staff person hired by a licensed assisted living facility may satisfy the following training requirements by providing written proof of previously completed training within the past 18 months. An evaluation of competency for accepted documentation of training in the past 18 months will be completed before the staff person provides assistance to residents. The RN onsite will observe and sign-off the newly hired staff member on the tasks prior to them providing care to residents on their own. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure four of four employees providing services (licensed assisted living director (LALD)-A, unlicensed personnel (ULP)-B, ULP-H, and registered nurse (RN)-D) completed an orientation to assisted living facility	01460		

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01460	Continued From page 45 licensing requirements and regulations before providing services to residents 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: LALD-A, ULP-B, ULP-H, and RN-D's records lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. LALD-A LALD-A had a start date of August 1, 2021 under the assisted living with dementia care license. ULP-B ULP-B began providing direct care services for the licensee under the comprehensive license on October 27, 2021. On November 16, 2021, at 11:30 a.m. ULP-B was observed to administer insulin to R9. On November 18, 2021, at approximately 12:00 p.m. LALD-A stated ULP-B had been an employee for the licensee previously, and was a current employee at their "sister" facility. LALD-A indicated due to staffing shortages, they had asked ULP-B to work at this facility.	01460		

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01460	Continued From page 46 On November 18, 2021, at 1:30 p.m. LALD-A and director of nursing (DON)-E verified there was no current employee record for ULP-B. ULP-H ULP-H had a start date of August 1, 2021, under the assisted living with dementia care license. On November 16, 2021, at 9:02 a.m. ULP-H was observed administering medications. RN- D RN-D was hired on August 5, 2021, to provide nursing services under the assisted living with dementia care license. During the entrance conference at approximately 11:30 a.m. LALD-A identified RN-D was responsible for resident assessments, service plans, incident reports, and completing medication orders for the 300 and 400 hallways. On November 18, 2021, at approximately 10:25 a.m. the LALD-A confirmed none of the licensee's current employees had received orientation to assisted living facility licensing requirements training. The licensee's Assisted Living and Assisted Living with Memory Care Orientation- ALL Staff policy revised October 8, 2021, noted employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following topics: - An overview of Minnesota's assisted living law - An introduction and review of agency policies and procedures related to the provision of	01460		

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01460	Continued From page 47 assisted living services. - Emergency and disaster training - Employee Right to Know -The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights. - Infection control - HIPAA/ Privacy Practice - Employee job description - Organizational chart and roles of staff within the facility - Principles of person-centered planning and service delivery and how they apply to direct support services -Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure - Maltreatment of vulnerable adults - How to report maltreatment of vulnerable adults - How to report a crime - Complaint process The licensee's Personal Records policy revised October 11, 2021, noted a personnel file will be maintained for each paid employee, all regularly scheduled volunteers providing services, and each individual contractor of the facility providing services. The personnel records for each employee would include record of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	01540		

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01540	Continued From page 48 (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for four of four employees (unlicensed personnel (ULP)-B, licensed assisted living director (LALD)-A, registered nurse (RN)-D, and ULP-H), 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).	01540		

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01540	Continued From page 49 The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2021. ULP-B began providing assisted living services to residents on October 27, 2021. On November 16, 2021, at 11:30 a.m. ULP-B was observed to administer insulin to R9. ULP-B did not have an employee record or documentation that ULP-B completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of ULP-B's start date. A review of employee timesheets verified ULP-B was over 80 working hours of the employment start date. LALD-A LALD-A began providing assisted living services for the licensee on August 1, 2021. LALD-A's records lacked evidence of any required training related to dementia care. On November 18, 2021, at 10:25 a.m. LALD-A stated she had not completed any dementia training in the past year and confirmed there was no evidence of the required topics of dementia training in her employee file. ULP-H ULP-H began providing assisted living services for the licensee on August 1, 2021. ULP-H's record lacked evidence of any required training related to dementia care had been	01540		

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01540	Continued From page 50 completed in the last year. On November 16, 2021, at 9:02 a.m. ULP-H was observed administering medications to R3, R7 and R8. RN-D RN-D began providing assisted living services for the licensee on August 1, 2021, and was responsible for resident assessments, service plans, incident reports, and completing medication orders for the 300 and 400 hallways. RN-D's record lacked evidence of any required training related to dementia care. November 18, 2021, at 2:20 p.m. LALD-A stated that if any of the required trainings were not in the employee files, then they had not been completed. The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy revised October 8, 2021, noted supervisors of direct-care staff would complete a minimum of 8 hours initial training within 120 working hours of the employment start date, and direct-care employees would complete a minimum of 8 hours initial training on dementia care topics within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		

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01620	Continued From page 51	01620		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment for one of one resident (R6). In addition, the RN failed to conduct a reassessment not to exceed 90 days for one of one resident (R4) as required with records reviewed. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 52 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: R6 R6's diagnoses included, but were not limited to, diabetes mellitus and hypertension (high blood pressure). R6's Service Plan dated July 9, 2021, indicated the resident received services including dressing and medication administration. R6's last two assessments were requested. 90 day assessments dated June 8, 2021, and August 26, 2021, were provided. On November 16, 2021, at 12:00 p.m. R6 stated she had tripped and fell in her room a couple months ago, breaking her left arm. R6 indicated since that had occurred she required more assistance from staff to shower and apply her arm sling. On November 17, 2021, at 2:13 p.m. RN-C stated R6 had fallen and sustained a left arm fracture on September 10, 2021. RN-C verified a change in condition assessment had not been completed for R6 and should have been. RN-C indicated anytime there is an event in which a resident would require more or less assistance, a new assessment should be completed. R4	01620		

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01620	Continued From page 53 R4's diagnoses included, but were not limited to diabetes mellitus, obesity, dementia (memory disorder), and hypertension (high blood pressure). R4's Service Plan dated July 23, 2021, indicated R4 received services which included medication administration and blood glucose checks. R4's last two assessments were requested. 90 day assessments dated July 22, 2021, and October 22, 2021, were provided. The October 22, 2021 assessment was 92 days after the previous assessment (2 days late). On November 16, 2021, at 3:00 p.m. RN-C verified R4's 90 day assessment dated October 22, 2021, was two days late. The facility's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy revised October 11, 2021, indicated the RN would re-assess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from he last date of the assessment. The RN will reassess the resident if the resident has a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t	01640		

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01640	Continued From page 54 (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, 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 one of five residents (R6) service plans were revised to reflect the current services provided. 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:	01640		

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(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
01640	Continued From page 55 R6's record lacked documentation the service plan was revised each time a new service was added. R6's diagnoses included, but was not limited to, diabetes mellitus and hypertension (high blood pressure). R6's Service Plan dated July 9, 2021, indicated R6 received services which included dressing and medication administration. The Service Plan did not identify R6 received assistance with bathing. On November 15, 2021, at approximately 11:50 a.m. R6 was observed wearing a left arm sling and ambulate using a hemi-walker. At this time, unlicensed personnel (ULP)-B stated she had assisted R6 with a shower in the morning. On November 16, 2021, at 12:00 p.m. R6 stated she had tripped and fell in her room a couple months ago, breaking her left arm. R6 indicated since then, she required assistance from staff to shower and apply her arm sling. On November 17, 2021, at 3:00 p.m. licensed assisted living director (LALD)-A indicated she was responsible for getting the revisions to service agreements completed. LALD-A indicated anytime a resident would require more or less assistance, a new Service Plan should be completed. LALD-A confirmed no revision had been completed for R6, and should have been. The licensee's Contents of Service Plans policy revised October 18, 2021, indicated service plans would be revised as needed based upon on-going resident assessment. No further information was provided.	01640		

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01640	Continued From page 56 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date open for three of three residents (R7, R3, R8) and failed to ensure medications were maintained bearing the original prescription label with legible information for two of two residents (R7, R9) with medication storage 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: On November 16, 2021, starting at 9:02 a.m.	01890		

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01890	Continued From page 57 unlicensed personnel (ULP)-H was observed administering medications to R7, R3 and R8. Medications were stored in east wing medication cart. R7 At 9:02 a.m., ULP-H was observed administering timolol 0/5% eye drops (glaucoma) to R7. R7's timolol was stored in a white bin labeled with R7's name. The timolol eye drops lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been dispensed. The timolol also did not have a date opened noted on the bottle. ULP-H stated she knew it was R7's medication as it was in a white bin labeled with R7's name. Timolol manufacturer guidelines indicated timolol should be discarded four weeks after opening. R3 At 11:13 a.m., ULP-H was observed to administer Humalog KwikPen insulin (fast acting insulin) to R3. The insulin pen did not have an open date or an expiration date. ULP-H stated it should have had the date open written on the pen or a sticker. ULP-H stated they were to use the pen until it was empty, and was unaware of how long Humalog was good after it was opened. Humalog KwikPen manufacturer guidelines indicated the insulin should be discarded 28 days after opening.	01890		

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01890	Continued From page 58 R8 At 11:10 a.m., ULP-H was observed administering Lispro insulin (fast acting insulin) to R8. The Lispro insulin pen did not have an open date or an expiration date. ULP-H stated it should have had the date open written on the pen or a sticker. ULP-H stated they were to use the pen until it was empty, and was unaware of how long Lispro was good after it was opened. Lispro insulin manufacturer guidelines indicated the insulin should be discarded 28 days after opening. On November 16, 2021, at 11:30 a.m. a review of the west wing medication cart was completed. The following was observed and confirmed with ULP-B. R9's Humalog KwikPen was observed in a plastic box labeled with the resident's name; however, the insulin pen lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been dispensed. The pen had a date open of November 15, 2021, but lacked a date it would expire. On November 16, 2021, at 2:45 p.m. registered nurse (RN)-C and director of nursing (DON)-E stated insulins, eye drops and other date sensitive medications are to be labeled with the date they are opened and should be discarded per manufacturer guidelines. The licensee's Storage of Medications policy	01890		

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01890	Continued From page 59 revised October 6, 2021, noted until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 60 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon disposition, document in the resident's record the disposition of the medication including the medication's prescription number as applicable for one of one discharged resident (R1) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's discharge summary dated October 15, 2021, identified R1 was admitted on August 4, 2021, and went into the hospital on September 13, 2021. R1 required higher level of care and was discharged on October 15, 2021. R1 received services which included medication administration. It further identified R1's medications had been destroyed by nursing. An untitled form listed the date, medication, RX (prescription) number, quantity, nurse signature, and witness signature. R1's name was listed on the bottom of the form. On October 6, 2021 the following medications were listed with a prescription number hydrocodone/acetaminophen (narcotic pain medication) and pregabalin (nerve pain medication). The following medication were listed without a prescription number tab-a-vite	01910		

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01910	Continued From page 61	01910		

(multivitamin), melatonin (vitamin to help sleep), digoxin (cardiac rhythm), levothyroxine (thyroid), metformin (diabetes), omeprazole (gastric reflux), spironolactone (fluid retention), SMZ/TMP (antibiotic), torsemide (fluid retention), warfarin (blood thinner), vitamin D3, loratidine (allergies), and nystatin (fungal infection). On October 7, 2021, the following medication was listed without a prescription number docusate/senna (constipation). On November 5, 2021, the following medications were listed without a prescription number loratidine and tab-a vite.

On November 15, 2021, at 2:40 p.m. registered nurse (RN)-C stated she recorded the prescription number for narcotic or controlled medications; however, she was unaware the prescription number was required for all medications.

On November 15, 2021, at 2:46 p.m. director of nursing (DON)-E stated the prescription numbers should have been included in the disposition of medication.

The facility's Disposition or Disposal of Medications Policy dated October 6, 2021, identified staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01940	Continued From page 62	01940		
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 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 and implement a treatment or therapy management plan to include all required content for four of four	01940		

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01940	Continued From page 63 residents (R5, R4, R2, R3) with treatment 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 November 15, 2021, at approximately 11:20 a.m. director of nursing (DON)-E stated the licensee provided treatment management services to residents, including, but not limited to, blood glucose checks, braces, and ostomy care assistance. R5, R4, R2, and R3's records lacked a treatment management plan to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. R5 R5's Service Plan dated September 11, 2020, indicated R5 received services including, but not	01940		

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01940	Continued From page 64 limited to, glucometer checks, catheter care, dressing, bathing, and medication administration. On November 16, 2021, at approximately 11:43 a.m. unlicensed personnel (ULP)-B stated staff check R5's blood sugars. R5's prescriber orders dated September 20, 2021, included an order for blood glucose checks three times a day. R5's documented task services from October 20, 2021, through November 17, 2021, included blood glucose checks up to three times a day. R4 R4's Service Plan dated July 23, 2021, indicated R4 received services including, but not limited to, glucometer checks and medication administration. On November 17, 2021, at approximately 10:00 a.m. R4 stated staff checked his blood sugar "couple times per day". R4's prescriber orders dated July 16, 2021, instructed staff to check blood sugars three times per day (before breakfast, evening meal, and bedtime). The order further instructed to contact provider if blood sugars were greater than 400. R4's task report for October 19, 2021, to November 17, 2021, included blood sugars up to three times daily to indicate the service was completed. On November 17, 2021, at approximately 12:41 p.m. registered nurse (RN)-C verified a treatment management plan with the required content had	01940		

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01940	Continued From page 65 not been developed for R5 or R4. R2 R2's Service Plan dated July 6, 2021, indicated R2 received services which included dressing, medication administration, and colostomy (an opening for the colon, or large intestine, through the abdomen) cares. On November 17, 2021, at 2:18 p.m. ULP-H was observed providing colostomy cares for R2. A physician order dated July 16, 2021, identified steps to complete for colostomy cares. R2's medical record lacked documentation of specific instruction for colostomy cares and when to notify a nurse if problems occurred. On November 17, 2021, at 10:15 a.m. RN-C stated the colostomy instructions were not in the "task" information for ULP. There were no instructions on how to complete the ostomy care and there were no instructions on when to notify a nurse if problems arose. R3 R3's Service Plan dated July 9, 2021, indicated R2 received services which included dressing, medication administration, and blood glucose monitoring. R3's prescriber orders dated October 6, 2021, instructed staff to check blood sugars three times per day. The order further instructed to contact the provider if blood sugars were greater than 450. On November 16, 2021, at 11:13 a.m. ULP-H was	01940		

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01940	Continued From page 66 observed to check R3's blood glucose and administer insulin to him. R3's November 2021, medication administration record (MAR) identified blood sugar checks with results three times a day. It further instructed if blood glucose was greater then 450, the staff were to notify the RN. There were no further instructions related to blood sugar monitoring and when to notify a nurse when blood sugar results were outside of parameters. Leg braces On November 18, 2021, at 8:32 a.m., ULP-H was observed placing bilateral leg braces on R3 ULP task documentation identified October 20, 2021, through November 17, 2021, brace care had been completed. There were no prescriber orders for the bilateral leg braces. An unlabeled and undated document was provided that was identified by DON-E as the ULP information on tasks for R3. The document identified, "Needs help with brace or prosthesis. [R3] wears braces daily for leg support. Staff will help [R3] put braces on in the AM and remove in the evening before bed. He Is unable to do this on his own at this time. Boot for the right foot until cleared after toe amputation. [R3] also has a vascular boot to promote circulation in his right foot. He states he may wear it at night and will need assist to put it on." The information lacked any specific instructions of when to notify a nurse. On November 17, 2021, at 11:30 a.m. DON-E stated residents should have an individualized treatment plan and resident specific instructions	01940		

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01940	Continued From page 67 to include when to notify a nurse for all treatments. The licensee's Individualized Treatment and Therapy Management Plan policy dated October 21, 2021, indicated a treatment and therapy management plan will be reviewed periodically and modified as needed, including: documentation of specific resident instruction relating to the treatments or therapy administration will be recorded in your (TAR); procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and any resident-specific requirements relating to documentation of treatment and therapy received, 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 will be current with specific resident instructions and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the	01950		

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01950	Continued From page 68 appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for four of four residents (R5, R4, R2, R3) with treatments and 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: R5 R5's diagnoses included, but were not limited to, multiple sclerosis (a disease that impacts the	01950		

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01950	Continued From page 69	01950		

brain and spinal cord) and diabetes.
R5's Service Plan dated September 11, 2020, indicated R5 received services which included bathing, catheter care, dressing, blood glucose checks, and medication administration.
R5's prescriber orders dated September 20, 2021, included an order for blood glucose checks three times a day.
R5's task report (intended as documentation of the delegated treatment task of blood sugar results) dated October 20, 2021, through November 17, 2021, listed: record blood sugar up to three times a daily. R5's record lacked specific written instructions related to blood sugar monitoring/parameters.

R4
R4's diagnoses included, but were not limited to, diabetes.
R4's Service Plan dated July 23, 2021, indicated R4 received services including, but not limited to, blood sugar checks and medication administration.

On November 17, 2021, at approximately 10:00 a.m. R4 stated staff checked his blood sugar "couple times per day".

R4's prescriber orders dated July 16, 2021, instructed staff to check blood sugars three times per day (before breakfast, evening meal, and bedtime). The order further instructed to contact provider if blood sugars greater than 400.

R4's task report (intended as documentation of the delegated treatment task of blood sugar results) dated October 19, 2021, to November 17, 2021, listed: recorded blood sugar up to three times daily. R4's record lacked specific written instructions related to blood sugar monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30450	A. BUILDING: _____ B. WING _____	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

(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
01950	Continued From page 70 On November 17, 2021, at approximately 3:55 p.m. RN-C confirmed R5 and R4's record did not have specific instructions. R2 R2's Service Plan dated July 6, 2021, indicated R2 received services which included dressing, medication administration, and colostomy (an opening for the colon, or large intestine, through the abdomen) cares. On November 17, 2021, at 2:18 p.m. ULP-H was observed providing colostomy cares for R2. A physician order dated July 16, 2021, identified steps to complete for colostomy cares. R2's medical record lacked documentation of specific instruction for colostomy cares. On November 17, 2021, at 10:15 a.m. RN-C stated the colostomy instructions were not in the "task" information for the ULP. There were no instructions on how to complete the ostomy care. In addition, the ULP trained each other in colostomy cares. The RN did not complete the training or provide instructions for colostomy cares. On November 17, 2021, at 11:30 a.m. director of nursing (DON)-E stated residents should have an individualized treatment plan and resident specific instructions for colostomy care. In addition, an RN should train on colostomy cares and a competency should be completed with the staff prior to performing the cares. R3	01950		

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01950	Continued From page 71 R3's Service Plan dated July 9, 2021, indicated R2 received services which included dressing, medication administration, and blood glucose monitoring. On November 18, 2021, at 8:32 a.m. ULP-H was observed placing bilateral leg braces on R3. The prescriber orders lacked an order for bilateral leg braces. ULP task documentation identified October 20, 2021, through November 17, 2021, brace care had been completed. An unlabeled and undated document was provided that was identified by director of nursing DON-E as the ULP information on tasks for R3. The document identified, "Needs help with brace or prosthesis. [R3] wears braces daily for leg support. Staff will help [R3] put braces on in the AM and remove in the evening before bed. He Is unable to do this on his own at this time. Boot for the right foot until cleared after toe amputation. [R3] also has a vascular boot to promote circulation in his right foot. He states he may wear it at night and will need assist to put it on." The information lacked any specific instructions. On November 17, 2021, at 11:30 a.m. DON-E stated residents should have an individualized treatment plan and resident specific instructions. The facility's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy revised October 6, 2021, noted the RN may delegate to unlicensed personnel the administration of medications, treatment, and therapy if the unlicensed personnel have satisfied the training requirements and the RN has	01950		

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COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

(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
01950	Continued From page 72 developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for two of four residents (R5 and R4) reviewed who received 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).	01960		

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COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

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01960	Continued From page 73 The findings include: R5's diagnoses included, but were not limited to, multiple sclerosis (a disease that impacts the brain and spinal cord) and diabetes. R5's Service Plan dated September 11, 2020, indicated R5 received services, which included bathing, catheter care, dressing, blood glucose checks, and medication administration. R5's prescriber orders dated September 20, 2021, included an order for blood glucose checks three times a day. R5's documented task services from October 20, 2021, through November 17, 2021, included blood glucose checks up to three times a day; however, it lacked documentation R5 received blood glucose checks on 28 of the 87 opportunities. On November 17, 2021, at 12:41 p.m. registered nurse (RN)-C stated R5's record should have documentation of blood sugars three times per day as ordered. RN-C confirmed this was lacking in R5's record. R4 R4's diagnoses included, but were not limited to, diabetes. R4's Service Plan dated July 23, 2021, indicated R4 received services including, but not limited to, blood glucose (sugar) checks and medication administration. On November 17, 2021, at approximately 10:00	01960		

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COLONY COURT	200 22ND AVENUE NE WASECA, MN 56093

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01960	Continued From page 74 a.m. R4 stated staff checked his blood sugar "couple times per day". R4's prescriber orders dated July 16, 2021, instructed staff to check blood sugars three times per day (before breakfast, evening meal, and bedtime). The order further instructed to contact the provider if blood sugars were greater than 400. R4's documented task services from October 19, 2021, to November 17, 2021, included blood sugar checks up to three times daily; however, it lacked documentation that R4 received blood sugar checks on 27 of the 87 opportunities. The licensee's Documentation of Medication, Treatment and Therapy Management Services revised October 4, 2021, indicated staff will document each task immediately after that task has 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.	01970		

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01970	Continued From page 75 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of four 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). The findings include: During the entrance conference on November 15, 2021, at approximately 11:20 a.m. director of nursing (DON)-E confirmed the licensee provided treatment services to the licensee's residents. R3's Service Plan dated July 9, 2021, indicated R2 received services which included dressing, medication administration, and blood glucose monitoring. On November 18, 2021, at 8:32 a.m. ULP-H was observed placing bilateral leg braces on R3. ULP task documentation identified October 20, 2021, through November 17, 2021, brace care had been completed. An unlabeled and undated document was provided that was identified by DON-E as the	01970		

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01970	Continued From page 76 ULP information on tasks for R3. The document identified, "Needs help with brace or prosthesis. [R3] wears braces daily for leg support. Staff will help [R3] put braces on in the AM and remove in the evening before bed. He Is unable to do this on his own at this time. Boot for the right foot until cleared after toe amputation. [R3] also has a vascular boot to promote circulation in his right foot. He states he may wear it at night and will need assist to put it on." R3's physician orders dated October 6, 2021, lacked an order for braces. On November 17, 2021, at 11:30 a.m. DON-E stated there should have been a physician order for braces for R3. The licensee's Treatment and Therapy Administration Record policy dated October 21, 2021, noted staff would provide ordered or prescribed treatment and therapy services. The treatment and therapy management plan will be reviewed periodically and modified as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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 77 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 of the physical environment specific to the facility, as required by MN Statute 144G.81 Subd.1 (a). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 resident s). The findings include: On November 9, 2021, between approximately 8:25 a.m. and 9:10 a.m. a record review and interview were conducted with the Maintenance Supervisor (MS)-G and Licensed Assisted Living Director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility. Based on this record review, the facility did not have a record of a hazard vulnerability assessment for the physical environment on or around the property. An interview conducted with	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 78 MS-G and LALD-A indicated they were not aware the facility had any sort of hazard vulnerability assessment outside of the items provided in Appendix Z. Between approximately 10:55 a.m. and 11:30 a.m. an exit interview was conducted with MS-G, LALD-A, and director of nursing (DON)-E. During this interview, DON-E provided a hazard vulnerability assessment that did not assess hazards of the physical environment of the facility and did not prescribe any mitigation factors for the identified hazards. A policy was requested for the hazard vulnerability assessment, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all	02140		

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02140	Continued From page 79 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 15, 2021, at approximately 11:20 a.m. licensed assisted living director (LALD)-A identified she, along with director of nursing (DON)-E, oversaw training staff in the care of individuals with dementia. On November 18, 2021, at 3:23 p.m. DON-E stated she had not completed the any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care, nor had LALD-A. They were unaware of the requirement. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	02140		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/16/21*
Time: 08:36:04
Report: 8044211371

Food and Beverage Establishment Inspection Report

Location:
Colony Court
200 22nd Avenue NE
Waseca, MN56093
Waseca County, 81

Establishment Info:
ID #: 0038264
Risk:
Announced Inspection: No

License Categories:
Assi

Expires on: / /

Operator:

Phone #: 5078376100
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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

Illnesses for dietary staff not recorded.

Comply By: 11/16/21

3-500A Microbial Control: cooling

3-501.14A ** Priority 1 **

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

Chicken noodle soup in walk-in cooler from 11/15 measured at 47 degrees F.

Soup discarded on site.

Comply By: 11/16/21

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Whipped butter stored on counter without mechanical refrigeration.

Butter moved to walk-in cooler upon request.

Foods measured above 41 degrees in walk-in cooler.

Maintenance has called plumber for repair.
Comply By: 11/16/21

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Chicken noodle soup in WIC dated 10/27.

Soup discarded on site.
Comply By: 11/16/21

2-300 Personal Cleanliness

2-301.15 ** Priority 2 **

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

Observed staff use three compartment sink to was hands.
Comply By: 11/16/21

2-300 Personal Cleanliness

2-301.15 ** Priority 2 **

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

Observed staff dry dishes with paper towels.
Comply By: 11/16/21

3-500A Microbial Control: cooling
3-501.15A ** Priority 2 **
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Chicken noodle soup cooled in covered plastic container.
Comply By: 11/16/21

4-600 Cleaning Equipment and Utensils
4-601.11A ** Priority 2 **
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Soil residues on blade of can opener.
Comply By: 11/16/21

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Certificate expired.
Comply By: 12/16/21

2-400 Hygenic Practices
2-401.11B
MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

Staff consuming beverages out of soda cans and bottles.
Comply By: 11/16/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

Boxes of food stored on floor in dry storage rooms.

Comply By: 11/16/21

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

Deteriorating and missing silicone caulking on backsplash of prep and three compartment sinks; dishwashing table.

Comply By: 12/16/21

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

Mildew growth inside ice machine.

Comply By: 11/16/21

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

Boxes of food containers store on floor in dry storage rooms.

Comply By: 11/16/21

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 151.8 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 44.0 Degrees Fahrenheit - Location: Salami in WIC
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46.6 Degrees Fahrenheit - Location: Sour cream in WIC
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 44.1 Degrees Fahrenheit - Location: Cottage cheese in WIC
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 43.6 Degrees Fahrenheit - Location: Sliced cheese in WIC
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 45.0 Degrees Fahrenheit - Location: Milk in WIC
Violation Issued: Yes

Process/Item: Cooling
Temperature: 47.1 Degrees Fahrenheit - Location: Chicken noodle soup from 11/15
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: Upright cooler in serving kit chen
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36.3 Degrees Fahrenheit - Location: Milk in upright cooler in serving kitchen
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	4	6

Santiarian Comments:

Report reviewed with director, Tami and person in charge, Patty.

Report emailed to Susan Kalis, HRD Nursing Evaluator.

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 Department of Health inspection report number 8044211371 of 11/16/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Patty

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us