Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 20, 2023

Licensee
Speltz Estates Assisted Living
232 Fremont Street South
Lewiston, MN 55952

RE: Project Number(s) SL30387015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH 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 MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

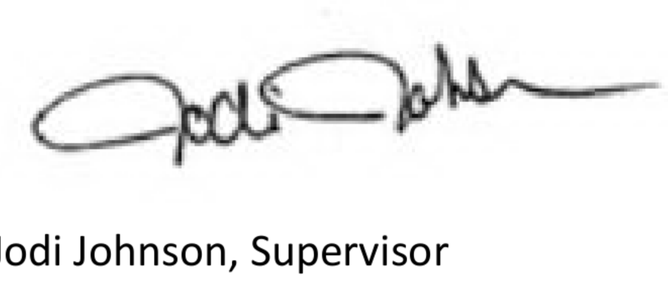
Please address your cover letter for reconsideration requests to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30387015-0 On August 28, 2023, through August 31, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 active residents; 12 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State 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.	
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of two unlicensed personnel (ULP-E, ULP-D) during medication administration and while performing personal cares. 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 August 29, 2023, at 6:50 a.m. ULP-E was observed to set up R5's medications outside of R5's unit. ULP-E donned (applied) clean gloves,	0 510		

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0 510	Continued From page 2 opened the locked medication locker, pulled out R5's medication bucket which included a combination of bubble packs and medication strips which held several medications. ULP-E referenced the electronic medication record (eMAR) on her tablet, confirmed the oral medications to be set up, picked up two separate bubble packs and punched the tablets from the bubble packs directly into her gloved hand, placed the medications in a paper cup, and then prepared the remaining medications found in prefilled medication strips. ULP-E failed to practice the proper procedure in medication set up when she put medications directly into her gloved hand after touching multiple surfaces. On August 29, 2023, at 8:56 a.m. ULP-D was observed to provide morning cares to R8 in his unit. ULP-D donned clean gloves, assisted R8 with clean socks, placed a clean incontinent pull up brief and clean pants to the level of his knees. With the same gloves, ULP-D gathered a clean soapy washcloth and washed R8's face and hands as he laid in bed. ULP-D then removed R8's wet incontinent brief, washed his peri-area, assisted him to a sitting position at the side of the bed and with the same gloves, obtained a clean soapy washcloth, washed his back, put on his shirt, and scratched his back itch (per R8's request). ULP-D then placed the EZ-stand (a mechanical lift system) sling behind him, attached the sling straps to the stand, stood him up, washed his bottom, placed an additional liner inside his brief, and pulled up his pants. ULP-D then removed her gloves, and immediately moved R8 to his wheelchair. ULP-D donned clean gloves, combed R8's hair, gathered his dirty bed protector, wet/soiled brief and threw them in the garbage. ULP-D then removed her gloves and without hand hygiene, pushed R8 to the	0 510		

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0 510	Continued From page 3 dining area for breakfast and then washed her hands. ULP-D failed to perform proper hand hygiene in between steps of working with soiled and unsoiled areas of R8's body and failed to perform proper hand hygiene in-between glove use. On August 29, 2023, at 10:30 a.m. clinical nurse supervisor (CNS)-C stated she had just reviewed handwashing and glove use with the staff at a recent staff meeting. She stated her expectation was for staff to avoid touching medications with their hands even if using gloves after touching other surfaces/items. Additionally, CNS-C stated she taught staff when providing personal cares, to always work from the cleanest area of the body and end with the dirtiest area, such as when providing peri-care. When staff provided peri-care, they were expected to change their gloves and perform hand hygiene prior to moving on to other parts of the body or touching other surfaces/items. The licensee's Hand Hygiene policy dated August 1, 2022, indicated hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 R1's diagnoses included pulmonary embolism (blood clot in the lung), spinal cord injury, type 2 diabetes (the body's inability to manage blood	0 630		

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0 630	Continued From page 5 sugar), essential tremor (hand tremors), and high blood pressure. R1 was admitted to the facility on October 26, 2013. R1's Individual Abuse Prevention Plan dated June 10, 2023, identified R1 had vulnerabilities due to his need for assistance with bathing, dressing, medication administration, and housekeeping; however, it identified that R1 was not at risk for abuse from others. In addition, R1's Individual Abuse Prevention Plan failed to identify specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease), high blood pressure, depression, anxiety, neuropathy and alcoholism. R2 was admitted to the facility on January 17, 2019. R2's Individual Abuse Prevention Plan dated June 10, 2023, identified R1 had vulnerabilities due to need for assistance for finances, impaired judgement and history of alcohol abuse. R2's IAPP indicated his susceptibility for abuse by others but lacked any indication as to his risk to abuse other vulnerable adults. On August 29, 2023, at 10:30 a.m. clinical nurse supervisor (CNS)-C reviewed R1 and R2's IAPPs and confirmed R1's IAPP lacked his susceptibility to abuse by others and stated, "I do understand all the residents here are susceptible to abuse by others as they are vulnerable adults receiving	0 630		

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0 630	Continued From page 6 services." Furthermore, CNS-C stated she would make a note to ensure each resident's IAPP addressed their susceptibility to abuse others, as this option in the electronic record was not automatically populated to answer yes or no or capture this requirement. The licensee's Vulnerable Adult Maltreatment policy dated August 1, 2022, indicated each resident receiving nursing services will have a written individualized abuse prevention plan. The plain would include: a. Residents' potential to abuse another individual/vulnerable adult; b. Resident's risk of abusing other vulnerable adults; c. Interventions to minimize the risk of abuse to the resident and other vulnerable adults No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with	0 640		

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0 640	Continued From page 7 information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting 911 emergency number as required. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 28, 2023, at 12:20 p.m. during a facility tour with licensed assisted living director (LALD)-A, the surveyor noted no 911 emergency number posted in the facility common areas or by facility supplied telephones as required. At 1:00 p.m., LALD-A stated there was no 911 emergency posting in the facility and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 9 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 the residents). The findings include: During the entrance conference on August 28, 2023, at 11:00 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's emergency preparedness plan last reviewed August 2022, lacked the following required content: - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the	0 680		

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0 680	Continued From page 10 facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); and - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and	0 680		

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0 680	Continued From page 11 On August 31, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A, LALD-B, and LALD-C reviewed the facility Disaster Plan with the surveyor, LALD-C stated she was the main person responsible to develop and implement the EPP, had worked on some of the required content, but not all was completed, and stated the above content was missing. LALD-C further stated they did not review the Missing Person policy quarterly as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents.	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(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
0 800	Continued From page 12 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). Findings include: On facility tour with the Licensed Assisted Living Director (LALD)-A between approximately 9:00 AM and 11:30 AM on August 29, 2023, it was observed that the occupant of Room 9 required oxygen as a medical aid. The entrance to the room did not have a sign indicating the use of oxygen/no smoking as required. This deficient condition was visually verified by (LALD)-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730		

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01730	Continued From page 13 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

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01730	Continued From page 14 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: R1 R1's diagnoses included diabetes mellitus (when the body cannot adequately manage blood sugar). R1's Service Plan dated July 27, 2023, indicated R1 received services to include medication assistance. On August 28, 2023, at 12:45 p.m. unlicensed personnel (ULP)-D was observed to enter R1's room and obtained R1's insulin pen and needle tip from his locked medication drawer. ULP-D asked R1 what his blood sugar was prior to lunch and followed the baseline insulin dosing along with the sliding scale used to determine the proper dose of insulin. ULP-D explained R1 was to attach the insulin pen needle independently and self-administer after he showed staff that he dialed the pen to the proper number of units (dose). R1 then attached a clean needle end to the insulin pen without wiping the pen tip, and dialed the insulin pen to 9 units, showed it to ULP-D and self-administered the insulin to his lower abdomen, and held it in place for about six seconds, withdrew the needle from his abdomen, detached the needle and disposed of it in the designated sharps container. R1's Medication Administration Record (MAR)	01730		

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01730	Continued From page 15 dated August 2023, indicated he received Novolog 100 units/milliliter (u/ml) subcutaneous (under the skin), three times daily with nine units after breakfast, ten units after lunch, ten units after supper. Additionally, R1's orders included an insulin sliding scale dose given in addition to his scheduled doses (given dependent on his blood sugar), indicated when blood sugars were less than 140-no additional insulin, if 141-155 give 1 unit, if 156-170 give 2 units, if 171-185 give 3 units, if 186-200 give 4 units, if 201-215 give 5 units, if 216-230 give 6 units, if 231-245 give 7 units, if 246-260 give 8 units, if 261-275 give 9 units, if 276-290 give 10 units, if 291-305 give 10 units, if greater than 305 call the registered nurse (RN). Review of August 2023, MAR indicated several entries which included a circle around the ULP initials. The MAR legend indicated the circle was related to the resident declining or skipping the medication. Review of the "Med Admin Summary" page indicated entries that R1 "did not receive his Novolog Insulin-Did not come out for breakfast" on the following dates: August 1, 2, 3, 4, 5, 6, 8, 9, 11, 13, 14, 20, 21, 23, 25, 27, 2023. On August 29, 2023, at 1:00 p.m. licensed assisted living director (LALD)-A stated the ULP have been told by the RN to hold R1's insulin when he had not eaten a meal; however, LALD-A was not aware if this direction was written anywhere. R1's Individualized Medication Management Plan dated June 10, 2023, indicated in section labeled Med Management-Risk due to complex medication regimen-High alert medication: insulin. In the section labeled Self-Admin of Meds, "Can correctly administer subcutaneous injections (injections under the skin), note/comment-Yes, staff observe pen to ensure	01730		

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01730	Continued From page 16 he dialed the correct dose. very shaky. uses safety pens so needle doesn't bend. Additionally, in summary, may self administer prn (as needed) medications, insulin, topicals (on the skin), inhalers and eye drops. Will not self administer prescribed scheduled oral meds." The licensee failed to indicate what instructions to follow for insulin administration when R1 chose not to eat a meal. On August 30, 2023, at 11:00 a.m. clinical nurse supervisor (CNS)-C reviewed R1's Medication Management Plan and stated she thought she had indicated there for staff to hold R1's insulin if he had not eaten breakfast. CNS-C further stated the written direction was not included in R1's plan and would add it. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed personnel policy dated August 1, 2022, indicated the RN had developed written, specific instruction for each resident. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01750		

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01750	Continued From page 17 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; 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 two of two unlicensed personnel (ULP-D, ULP-E) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 diagnoses included type two diabetes (when the body cannot regulate it's blood sugar). R1's Service Plan dated July 27, 2023, indicated R1 received services to include medication assistance. R1's provider's orders dated October 7, 2022, included Novolog 100 units/milliliter (u/ml) subcutaneous (under the skin), three times daily with nine units after breakfast, ten units after lunch, ten units after supper. Additionally, R1's	01750		

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01750	Continued From page 18 orders included an insulin sliding scale dose given in addition to his scheduled doses (given dependent on his blood sugar), indicated when blood sugars were less than 140-no additional insulin, if 141-155 give 1 unit, if 156-170 give 2 units, if 171-185 give 3 units, if 186-200 give 4 units, if 201-215 give 5 units, if 216-230 give 6 units, if 231-245 give 7 units, if 246-260 give 8 units, if 261-275 give 9 units, if 276-290 give 10 units, if 291-305 give 10 units, if greater than 305 call the registered nurse (RN). On August 28, 2023, at 12:45 p.m. ULP-D was observed to enter R1's room and obtained R1's insulin pen and needle tip from his locked medication drawer. ULP-D asked R1 what his blood sugar was prior to lunch and followed the baseline insulin dosing along with the sliding scale used to determine the proper dose of insulin. ULP-D explained R1 was to attach the insulin pen needle independently and self administer after he showed staff that he dialed the pen to the proper number of units (dose). R1 then attached a clean needle end to the insulin pen without wiping the pen tip, and dialed the insulin pen to 9 units, showed it to ULP-D and self administered the insulin to his lower abdomen, and held it in place for about six seconds, withdrew the needle from his abdomen, detached the needle and disposed of it in the designated sharps container. ULP-D stated she was observed by the registered nurse in the procedure for insulin pen administration and was not aware of the need to wipe the insulin pen tip or prime the insulin pen with two units (or as per manufacturer's instructions) of insulin prior to dialing to the proper dose. R6	01750		

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01750	Continued From page 19 R6's diagnoses included type two diabetes. R6's Service Plan dated July 27, 2023, indicated R6 received services to include medication assistance. R6's provider's orders dated March 10, 2023, indicated Basaglar Kwikpen 100 u/ml, subcutaneous twice daily for diabetes. Resident to self-administer 32 units in the morning and 30 units at bedtime. Assist and monitor self-dial and administration-verify number on the dial. Encourage her to have a snack before she administers her insulin- juice and toast in the morning if not eating breakfast and something in the evening-yogurt? Additionally, R6 has an order for Novolog insulin 100 U/ml subcutaneous once daily, within 20 minutes of eating lunch. Self-administered, staff to verify correct units and assists as needed. On August 29, 2023, at 7:45 a.m. ULP-E was observed to assist R6 with oral medications and gathered the needed supplies for R6's insulin pen injection. R6 performed her own blood sugar check (262), ULP-E provided a newly opened insulin cartridge from the mini-refrigerator in R6's room, wrote the "opened date" on the new cartridge as required, and handed the cartridge pen and new needle to R6. R6 attached the new needle, dialed the insulin pen to 32 units and self-injected into her lower abdomen, held in place for about six seconds, withdrew the insulin pen, detached the needle, and disposed of it in the designated sharps container. ULP-E indicated she was trained and observed by the registered nurse regarding the insulin pen procedure and was not aware of the need to wipe the needle tip prior to a new needle attachment and was not aware of the need to prime the	01750		

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01750	Continued From page 20 insulin pen/needle with insulin prior to administration of insulin. On August 29, 2023, at 10:30 a.m. clinical nurse supervisor (CNS)-C stated the licensee required those residents who received insulin be able to attach the insulin pen needle tip, dial the pen to the appropriate dose of insulin as confirmed by the ULP and self-administer the injection. The ULP were to observe the residents for the proper procedure. CNS-C stated she was not aware of the manufacturer's direction to prime the insulin pen needle prior to dialing the appropriate insulin dosing and would retrain the staff to ensure this procedure was followed. CNS-C stated she would need to work with the staff and the residents who received insulin injections to educate them in the proper procedure and ensure the residents they were not "wasting" the insulin by priming the pen, as this would likely cause some distress for them if they felt to be wasting the insulin. The licensee's insulin pen procedure dated 2022, indicated remove the pen cap and clean tip with an alcohol wipe or per manufacturer's guidelines. Remove the inner cap on the needle. Prime the pen per manufacturer guidelines. Novolog manufacturer's instructions dated February 2023, indicated for the user to remove the flex pen cap and wipe the flex pen tip with an alcohol wipe prior to placing a new needle on the flex pen tip, prime the FlexPen with two units of insulin prior to dialing the FlexPen to the appropriate dose and then cleanse the skin prior to injection and hold the FlexPen in place for the count of six following injection. Basaglar manufacturer's instructions dated November 2022, indicated for the user to remove	01750		

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01750	Continued From page 21 the flex pen cap, wipe the flex pen tip with an alcohol wiper prior to placing a new needle, and prime the FlexPen with two units of insulin prior to dialing the FlexPen to the needed dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in two of two resident mini-refrigerators (R1, R6). Additionally, the licensee failed to ensure medications were securely stored for four of twelve residents (R1, R4, R5, R6). 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	01880		

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01880	Continued From page 22 situation has occurred repeatedly; but is not found to be pervasive). The findings include: TEMPERATURE SENSITIVE MEDICATIONS On August 28, 2023, at 12:45 p.m. unlicensed personnel (ULP)-D was observed to enter R1's unit and assisted him with his insulin pen set up. ULP-D stated R1's unopened insulin pens were stored in his mini-refrigerator in his unit. The mini-refrigerator temperature was not being monitor to ensure safe storage for temperature sensitive medications. The surveyor and ULP-D observed the contents of R1's mini-refrigerator to include the following: -Tresiba insulin cartridges-three pen cartridges with storage recommendations 36-46 degrees Fahrenheit (F); and -Novolog flex pens (insulin)-14 pens with storage recommendations 36-46 degrees F. On August 28, 2023, at 12:55 p.m. the surveyor and ULP-D reviewed the contents of R6's mini refrigerator which stored some of R6's medications and had not had temperature monitoring completed. The contents of R6's mini refrigerator included: -Basaglar Kwikpen 100 units/milliliter (U/ml)-four pens with storage recommendations 36-46 degrees F; -Novolog FlexPen-two pens with storage recommendations 36-46 degrees F; and -latanoprost eye drops 0.005% -three bottles with storage recommendations 68-77 degrees F. The licensee failed to store temperature sensitive medications according to the manufacturer's recommendations.	01880		

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01880	Continued From page 23 SAFE MEDICATION STORAGE On August 29, 2023, at 7:45 a.m. ULP-E was observed to prepare R6's Miralax powder (bowel medication) at the kitchen counter, she measured 17 grams of powder, placed it in a drinking cup and mixed with about eight ounces of water. ULP-E then placed the bottle of Miralax in an unlocked kitchen cupboard. ULP-E stated the resident's bowel medications were all kept in that cupboard for convenience and proximity to the kitchen sink. The following medications were also noted to be stored in an unlocked kitchen cupboard: -R1's Metamucil (bowel medication)-one bottle -R4's Miralax-one bottle -R5's Miralax-one bottle Additionally, R1 and R6's insulin pens and R6's eye drops as stored in their mini-refrigerators were not securely stored. The licensee failed to provide secured storage for all medications. On August 28, 2023, at 1:00 p.m. licensed assisted living director (LALD)-A stated she was not aware of the need to monitor the resident's mini refrigerator temperatures and did not think she could use a central storage refrigerator for this purpose. LALD-A stated she would work with the registered nurse to determine the best location for the insulin and eye drops and would ensure daily temperature monitoring. The licensee's Medication Storage policy dated August 1, 2022, indicated the RN would recommend where medications should be stored understanding that our agency may not be able to control where and how a resident stores his/her medications in their room. The RN would provide education to the resident/resident's representative on proper storage of medications in the home	01880		

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01880	Continued From page 24 including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and nursing office. When secured storage the medications are necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications contained a proper label to include an expiration date for one of three residents (R4) who received medication administration. 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(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
01890	Continued From page 25 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 28, 2023, at 1:42 p.m. unlicensed personnel (ULP)-D was observed to set up R4's acetaminophen (for mild pain) 500 milligram (mg) from a bubble pack noted to include a handwritten label. The 30-tablet bubble pack had nine remaining tablets of acetaminophen. The bubble pack lacked an expiration date. ULP-D stated the registered nurse set up R4's acetaminophen in the bubble packs from his bottled supply to better track administration and did not see an expiration date. ULP-D stated she did not know where the original bottle of acetaminophen was stored and could not confirm the medication was not expired. On August 28, 2023, at 2:35 p.m. licensed assisted living director (LALD)-A stated she became aware of the missing expiration date and was working with the registered nurse to correct. The licensee's Storage of Medications policy dated August 1, 2022, indicated 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 of 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.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	08/31/2023

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01890	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) 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 August 28, 2023, at 11:15 a.m. licensed assisted living director (LALD)-A and LALD-B confirmed the	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	08/31/2023

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SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

(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
01970	Continued From page 27 licensee provided treatment and therapy services to the licensee's residents. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease) with oxygen dependence. R2's Service Plan dated July 27, 2023, indicated R2 received the service of oxygen maintenance three times daily. R2's Services with Instructions document which provided detailed instructions regarding tasks for unlicensed personnel (ULP) and indicated Oxygen maintenance three times daily and included the instructions, "resident to use oxygen concentrator at two liters on continuous flow as needed for oxygen saturation levels less than 90% and at bedtime. Should not use when oxygen saturation is above 93%. Resident self-administers his oxygen. (Spare tank) in closet if there is a power outage. Additionally, the ULP were to provide assistance with changing the oxygen tubing every 90 days. On August 29, 2023, at 8:15 a.m. ULP-E was observed to enter R2's room to administer oral medications and an inhaler. R2 was in bed with his oxygen nasal cannula in place and the oxygen concentrator on at two liters/minute. ULP-E stated R2 self-managed his oxygen, but the ULP were tasked to ensure he had the concentrator on at the appropriate flow when needed each shift during the day and at bedtime and assisted with changing the oxygen tubing, "I think monthly". R2's record included an order for oxygen dated April 16, 2020. The licensee failed to ensure the treatment order for oxygen was renewed on an	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30387	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPELTZ ESTATES ASSISTED LIVING	232 FREMONT STREET SOUTH LEWISTON, MN 55952

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01970	Continued From page 28 annual basis. On August 30, 2023, at 11:00 a.m. clinical nurse supervisor (CNS)-C stated there was likely not an oxygen renewal order in R2's record. LALD-A stated R2 had received some mail correspondence and billing issues from the oxygen supply company, but R2 did not share this information with the licensee. The licensee's Renewal of Medication, Treatment, or Therapy Prescriptions and Orders policy dated August 1, 2021, indicated a medication prescription or a treatment or therapy order must be current and must be renewed at least every 12 months or more frequently as indicated by the assessment of the client by the CNS or the Licensed Health Professional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 29 entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 12 residents, staff, and visitors of the licensee. 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: Upon entrance to the facility on August 28, 2023, at 10:45 a.m. the surveyor observed the front entrance and entryway of the facility. No electronic monitoring signage was observed. On August 28, 2023, at 2:00 p.m. licensed assisted living director (LALD)-A stated they did not have electronic monitoring in place at this time and there was no sign displayed in statutory language to disclose possible electronic monitoring activity. LALD-A stated she was not aware of the regulation for this posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services Section
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/29/23*
Time: 10:08:18
Report: 1009231134

Food and Beverage Establishment Inspection Report

Location:

Speltz Estates Assisted Living
232 Fremont Street South
Lewiston, MN55952
Winona County, 85

Establishment Info:

ID #: 0038910
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074293335
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160.3 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Three compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Maytag, dressing, pasta salad
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Frigidaire, coleslaw
Violation Issued: No

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

Discussion:

Please be aware that Norovirus, often thought to be the "stomach flu" continues to be the leading cause of foodborne illness outbreaks. A person who has contracted
Norovirus continues to be contagious at least three days after symptoms have subsided. Because of this, it is important to report and record any illnesses, even if staff did not report to work while ill.

Also, to further reduce the risk of transmitting Norovirus and other pathogens that may cause illness, continue to closely monitor handwashing, proper cleaning and sanitizing of equipment and surfaces, and do not allow bare-hand contact with ready-to-eat foods. Illnesses are reported and recorded.

Very little illness has been reported recently.

Foods come from approved sources. They are checked at receiving for condition and temperature.

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QA sanitizer concentrations are monitored and logged daily to ensure the concentration is maintained at 200ppm to 400ppm. Test strips are on sit.

The NSF hot-water sanitizing dishmachine is monitored with a maximum recording waterproof "plate" thermometer daily and logged.

Foods in the coolers are monitored with a thermometer and recorded on a log sheet on the cooler door.

Temperature logs are well maintained. Corrective actions are noted when temperatures require adjustment.

Food cook temperatures are monitored as well.

Some cooling takes place, mainly soups. Soups are made concentrated, and ice is used as an ingredient to aid in rapid cooling. Ice wands are also used. If other foods are cooled that this method won't work for, ensure they are portioned into thin layers in shallow metal pans and placed quickly into the cooler uncovered. Plastic is a good insulator and tends to slow cooling while metal, being a good conductor, helps foods cool faster. Once foods reach 41 F or below, then they can be placed in deeper plastic or glass food containers and covered.

Plunkett's services the facility for pest management. No signs of pests seen today.

The water heater pressure relief valve terminates within 18 inches of the floor as required.

There is an air gap where the water softener discharge line terminates into the floor utility tub. Keep an eye on this line to ensure the air gap is maintained, and that it does not fall below the flood tim of the utility tub.

The facility is very clean and well maintained.

Type: Full
Date: *08/29/23*
Time: 10:08:18
Report: 1009231134
Speltz Estates Assisted Living

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 1009231134 of 08/29/23.

Certified Food Protection Manager: Michele Speltz

Certification Number: FM33272 Expires: 04/17/24

Inspection report reviewed with person in charge and emailed.

Signed:_____
Michele Speltz
CEO

Signed: Lesli Haines
Lesli Haines, RS/REHS
Public Health Sanitarian III
Rochester District Office
507-206-2745
lesli.haines@state.mn.us