Electronically Delivered

October 21, 2024

Licensee
Central Minnesota Senior Care
315 6th Street Southwest
Little Falls, MN 56345

RE: Project Number(s) SL20317015

Dear Licensee:

On September 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 17, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 7, 2024

Licensee
Central Minnesota Senior Care
320-632-2996
Little Falls, MN 56345

RE: Project Number(s) SL20317015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20317	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	320-632-2996 LITTLE FALLS, MN 56345

(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: SL20317015-0 On July 15, 2024, through, July 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine resident; nine receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 16, 2024, issued for SL20317015-0, tag identification 0470. On July 16, 2024, at 4:35 p.m., the immediacy of correction order 0470 was removed, however, non-compliance remained at a scope and level of I.	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had sufficient staffing 24 hours per day to meet the scheduled and reasonably foreseeable unscheduled needs for two of two residents (R4, R8). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order identified on July 16, 2024. The findings include: During the entrance conference on July 15, 2024, at 10:11 a.m., registered nurse (RN)-B stated the licensee was familiar with current minimum assisted living requirements. On July 15, 2024, at 10:15 a.m., licensed assisted living director (LALD)-A stated the licensee offered mechanical lifts as a service. On July 15, 2024, at 10:28 a.m., LALD-A stated the licensee staffed one unlicensed personnel (ULP) from the hours of 11:00 p.m. until 7:00 a.m. every night. The licensee's Monthly Schedule dated April 2024, May 2024, June 2024, and July 2024, respectively, indicated one ULP was scheduled each night for the eight-hour overnight shift. R4 R4's diagnoses included cerebral palsy and bipolar disorder. R4's service plan dated April 8, 2024, indicated R4 received assistance with medication administration, transfer assistance, showering, grooming, dressing, toileting, vital sign	0 470		

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0 470	Continued From page 3 monitoring, and light housekeeping. R4's 90 Day Assessment dated July 11, 2024, indicated staff used standing lift (PAL-portable, free-standing hoist to aide in safe resident transfers) for all transfers. A2 (assist of two staff) recommended per PT (physical therapy) with PAL transfers. R4 was incontinent of bladder and staff are to check and change incontinent produce every two hours and offer toileting. The 90 Day Assessment further indicated two staff assist with ALL PAL TRANSFER FOR [sic] the safety of client (resident) and staff. Staff will assist client (resident) verbally and/or physically in the event of an emergency and an evacuation is necessary as R4 is not able to evacuate without help. On July 15, 2024, at 12:43 p.m., the surveyor observed ULP-D and ULP-E transfer R4 with the PAL. Immediately following the observation, ULP-D stated R4 used the PAL lift for all transfers and the licensee always used two staff for R4's transfers. R8 R8's diagnoses included dementia, stroke, and glaucoma. R8's service plan dated July 11, 2024, indicated R8 received assistance with hoyer transfer, medication administration, showering, grooming, dressing, transfer assistance, and housekeeping. R8's 90-Day June 11, 2024, indicated R8 needed one to two staff assistance as needed for all transfers and use the PAL lift PRN (as needed). On July 16, 2024, at 7:47 a.m., ULP-H stated R8 was a two-person transfer with a hoyer and just received the hoyer recently from hospice.	0 470		

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0 470	Continued From page 4 On July 16, 2024, at 6:26 a.m. until 6:32 a.m., ULP-F stated ULP-F worked full time nights for the licensee and was the only staff member present for the over night shift. ULP-F stated ULP-F was trained by the licensee to use the PAL lift with one or two people. ULP-F further stated R4 is a two person PAL transfer and R4 does not usually request to be up at night. ULP-F stated ULP-F would not be able to get R4 up at nights and if there was an emergency ULP-F would "screw rules" and evacuate R4 with the PAL lift alone. On July 16, 2024, at 8:55 a.m., LALD-A stated R4 typically doesn't get up at night and if R4 requested to be up, the ULP could contact LALD-A and LALD-A would come in and assist with a two-person transfer. LALD-A further stated LALD-A lives six miles out of town. At 9:02 a.m., LALD-A stated R8 had a decline and was put on hospice services. LALD-A stated hospice brought in a hoyer for transfers a week or two ago, however, hasn't been used for transfers. On July 16, 2024, at 9:04 a.m., RN-B stated if R4 was assessed to have two staff complete a PAL transfer then at least two staff should be present 24 hours per day to assist at any time. RN-B further stated if R8 had a hoyer brought in for all transfers, the licensee should have staffed a least two people for all shifts. The licensee's Staffing Plan last reviewed July 10, 2024, indicated it (the licensee) will be ensured there is sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis. In addition, a	0 470		

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0 470	Continued From page 5 minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 29, 2024, indicated the licensee typically scheduled the number of ULPs for each of the following shifts: Day Shift: three ULPs Evening shift: two ULPs; and Night shift: one ULP. In addition, the UDALSA indicated mechanical lift: assist of two (staff) transfer was available. R4's undated Operator Manual (for the PAL/sit to stand) provided by the licensee, indicated on Page six: Regarding One or Two Person Transfers: There are several organizations that promote the use of a one person transfer in the appropriate circumstances. However, determining those conditions can be difficult. The patient's (resident's) characteristic and the training level of the staff can affect whether a one person or two person transfer is proper. In the final analysis, believe that the facility's staff is in the best position to assess the training level of the employees and determine the unique needs of each patient (resident) and to ultimately establish the appropriate guidelines. The manufacture's instruction for R8's Span-America's F500P Full Body Patient Lift (hoyer) dated July 18, 2022, (found on https://youtu.be/V6Hc-tDpwIQ?si=wA4XpdnQohuxxgnz) indicated transfer may require two or more	0 470		

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0 470	Continued From page 6 caregivers: assess patient (resident) first for safety. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on July 16, 2024, at 2:14 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	0 470		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, 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) and	0 660		

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0 660	Continued From page 7 Minnesota Department of Health (MDH), including a history and symptoms screening for active TB along with completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two 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 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 facility's TB risk assessment was completed on August 21, 2023, and the facility was determined to be a low risk level. CNS-C was hired on March 21, 2023, to provide direct care services to residents and supervision of staff at the assisted living facility. CNS-C's employee record contained a negative TST dated March 1, 2023. CNS-C's employee record lacked evidence of a history and symptoms screening for active TB and completion of a two-step TST or other evidence of TB screening such as a blood test. On July 16, 2024, at 12:17 p.m., registered nurse (RN)-B stated the licensee was unable to locate CNS-C's a history and symptom screening for active TB and the second TST. RN-B further stated upon hire all employees were required to complete a history and symptoms screening for	0 660		

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0 660	Continued From page 8 active TB and a two-step TST. The licensee's undated 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 Preventions Standards policy indicated screening all staff providing services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection would be documented in the services' [sic] file. The license's undated Tuberculosis Infection Control Program Staff Training and Education policy indicated employees would either receive the TB skin Test (TST) or TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (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	0 780		

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0 780	Continued From page 9 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 that complied with fire protection requirements. This had the potential to directly 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) 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 July 17, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and licensed assisted living director/executive director (LALD/ED)-I. During the tour, survey staff observed a smoke alarm was not installed in the bedroom for resident dwelling unit identified as GR room. During the facility tour interview, LALD-A and LALD/ED-I	0 780		

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0 780	Continued From page 10 stated they did not know why this smoke alarm was missing and would contact the fire protection company right away to schedule the alarm installation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required by statute. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20317	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	320-632-2996 LITTLE FALLS, MN 56345

(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
0 790	Continued From page 11 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and licensed assisted living director/executive director (LALD/ED)-I. During the tour, survey staff observed monthly inspections were not recorded on the back of the annual maintenance tags attached to the portable fire extinguishers. Records were not available to support monthly fire extinguishers inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During an interview on July 17, 2024, at 10:55 a.m., LALD/ED-I stated monthly fire extinguisher inspections were completed but this had not been documented. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 12 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 interview and record review, the licensee failed to conduct a comprehensive reassessment for one of three residents (R8) with a change of condition. 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 July 15, 2024, registered nurse (RN)-B stated change of	01620		

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01620	Continued From page 13 condition assessments would be conducted on residents for instances such as hospitalizations, change in services, or a change in condition. R8's diagnoses included dementia, stroke, and glaucoma. R8's service plan dated July 11, 2024, indicated R8 received assistance with hoyer transfer, medication administration, showering, grooming, dressing, transfer assistance, and housekeeping. R8's 90-Day June 11, 2024, indicated R8 needed one to two staff assistance as needed for all transfers and use the PAL lift (sit to stand lift) PRN (as needed). On July 16, 2024, at 7:47 a.m., ULP-H stated R8 was a two-person transfer with a hoyer and just received the hoyer recently from hospice. R8's record contained a 90-Day Assessment dated June 11, 2024. R8's record lacked a change of condition reassessment after being placed on hospice care and requiring a two-person hoyer transfer on July 11, 2024. On July 16, 2024, at 12:04 p.m., RN-B stated R8 had a significant change of condition, and an assessment should have been completed on R8, however, the licensee did not complete an assessment for R8, and RN-B was not sure why an assessment was not completed. The licensee's undated Conduction Initial and Ongoing Client/Resident Evaluations and Assessments of Resident Needs (including assessments by a RN or appropriate licensed	01620		

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01620	Continued From page 14 health professional) and How Changes in Client's/Resident's Condition are Identified, Managed, and Communicated to Staff and Other Health Care Providers as Appropriate [sic] policy indicated ongoing client (resident) monitoring and reassessment must be conducted as needed based on change in the needs of the client (resident). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content at the time of setup for one of one resident (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	01770		

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01770	Continued From page 15 a large portion or all of the residents). The findings include: During the entrance conference on July 15, 2024, at 10:15 a.m., registered nurse (RN)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included diabetes and chronic respiratory failure. R2's Service plan dated April 10, 2024, indicated R2 received medication administration, medication assistance, medication reminder, and insulin assistance. On July 16, 2024, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-H administer R2's scheduled morning medication. R2's prescriber orders dated May 8, 2024, included an order for Linzess 290 micrograms (mcg) take one tablet 30 minutes before breakfast daily. R2's medication administration record (MAR) dated July 2024, contained a line that indicated "in pill caddy" listed below the Linzess medication. R2's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. On July 16, 2024, at 10:12 a.m., RN-B stated licensed nursing staff did not document the setup of Linzess, however, RN-B was aware of the	01770		

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01770	Continued From page 16 medication setup requirements and will provide additional training to all licensed nursing staff. The licensee's undated Medication Management policy indicated to document the following at the time of the medication set up: the date of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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 were maintained bearing legible information including the opened-on date for time sensitive medication for one of one resident (R5). 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	01890		

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01890	Continued From page 17 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 July 15, 2024, at 10:15 a.m., registered nurse (RN)-B stated the licensee provided medication management services to residents at the facility. On July 15, 2024, at 12:56 p.m., the surveyor reviewed the medication room with unlicensed personnel (ULP)-D and observed R5's Ventolin Hydrofluoroalkane (HFA) inhaler was not labeled with an opened date or expiration date. On July 15, 2024, at 1:14 p.m., ULP-D stated ULP-D was trained to write open dates on all time sensitive medications. On July 15, 2024, at 2:27 p.m., RN-B stated RN-B was aware of dating time sensitive medications and ULPs were trained to indicate the open date on all time sensitive medications including creams, ointments and insulin. RN-B further stated RN-B was not aware inhalers required open dates. The manufacturer's instructions for Ventolin Hydrofluoroalkane (HFA) inhaler dated December 2014, directed to discard when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever, comes first. The licensee's undated Medication Management policy indicated a prescription drug, prior to being set up for immediate or later administration, must	01890		

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01890	Continued From page 18 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *07/15/24*
Time: 11:45:00
Report: 6808241091

Food and Beverage Establishment Inspection Report

Location:

Central Minnesota Senior Care
315 6th St SW
Little Falls, MN
Morrison County, 49

Establishment Info:

ID #: 0020317
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
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 170 Degrees Fahrenheit
Location: dishwasher final rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: pudding in kitchen refrigerator
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: pantry refrigerator
Violation Issued: No

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

Type: Full
Date: *07/15/24*
Time: 11:45:00
Report: 6808241091
Central Minnesota Senior Care

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 6808241091 of 07/15/24.

Certified Food Protection Manager: Jennie Bird

Certification Number: _____ Expires: 04/29/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us