DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 20, 2022

Administrator
Marcella Manor LLC
228 19th Street Sw
Rochester, MN 55902

RE: Project Number(s) SL34666015

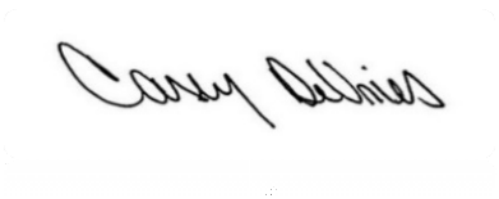
Dear Administrator:

On September 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Electronically Delivered

August 2, 2022

Administrator
Marcella Manor LLC
228 19th Street Southwest
Rochester, MN 55902

RE: Project Number SL34666015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34666	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARCELLA MANOR LLC	228 19TH STREET SW ROCHESTER, MN 55902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34666015 On July 11, 2022, through July 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living license. On July 11, 2022, the immediacy of correction orders 2310 has been removed; however, non-compliance remains at a scope and level level 3, isolated (G). On July 12, 2022, the immediacy of correction orders 1290 has been removed; however, non-compliance remains at a scope and level level 3, widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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: During the entrance conference on July 11, 2022,	0 250		

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0 250	Continued From page 3 at approximately 2:54 p.m., licensed assisted living director (LALD)-A stated the licensee ' s employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or	0 250		

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0 250	Continued From page 5 subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by licensed assisted living director (LALD)-A on May 20, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -conducting and handling background studies on employees; -a process for evaluating staff performance; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -implementation of the assisted living bill of rights; -conducting appropriate screenings, or	0 250		

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0 250	Continued From page 6 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0470, 0580, 0650, 0660, 0680, 0730, 0790, 0810, 0940, 1290, 1420, 1620, 1640, 1650, 1750, 1760, 1820, 1830, 1940, 1950, 2260, 2310, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (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	0 470		

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0 470	Continued From page 7 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 staffing plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted with all required information. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 12, 2022, at 9:39 a.m., posted on the wall inside the front entrance was a sheet of paper with the following information: "[the licensee name] Staffing Plan; 0700-1530 [7:00 a.m. to	0 470		

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0 470	Continued From page 8 3:30 p.m.] caregiver x 1; 1500-2330 [3:00 p.m. to 11:30 p.m.] caregiver x 1; 2300-0730 [11:00 p.m. to 7:30 a.m.] caregiver x 1; RN on-call 24x7 available via phone, text, and/or email; staffing plan based on resident acuity and reviewed regularly by director of nursing." STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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 STAFFING SCHEDULE The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; -direct-care staff member's resident assignments or work location; and -be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building On July 13, 2022, at 1:52 p.m., licensed assisted living director (LALD)-A stated, "I thought that was what you needed, my understanding", for the	0 470		

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0 470	Continued From page 9 required staffing plan developed and staffing schedule posted. The licensee Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The clinical nurse supervisor would develop a 24-hour daily staffing schedule that will identify: direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and the direct-care staff member's resident assignments or work location. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for	0 580		

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0 580	Continued From page 10	0 580		

two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all nine residents receiving assisted living services.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).

The findings include:

On July 13, 2022, at approximately 2:54 p.m., licensed assisted living director (LALD)-A stated, "Yes" the licensee had quality management and would provide the documentation.

On July 13, 2022, at 2:02 p.m., LALD-A stated she had "no documentation for quality management. We talk daily about what doing and have monthly meetings with staff and talk about goals. Falls last month and activities in January."

The licensee's Quality Management Project policy dated August 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two

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	34666	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARCELLA MANOR LLC	228 19TH STREET SW ROCHESTER, MN 55902

(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
0 580	Continued From page 11 years. Identified staff would, using data collected from logged resident complaints, outcomes from MDH (Minnesota Department of Health) surveys or investigations, outcomes from resident satisfaction surveys, or other sources of data, select at least one area to focus on in the form of a quality improvement initiative. Data should be collected on the target area to develop a baseline. Using a performance improvement methodology, such as Plan-Do-Check-Act (PDCA), a Performance Improvement Team (PIT) would be organized to enact the PDCA cycle. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not	0 640		

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0 640	Continued From page 12 posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect three (3) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 12, 2022, at 9:44 a.m., during observation of the facility, a facility phone was located in the kitchen area. There was no posted 911 emergency number and the required MAARC information posted in common areas or near the telephone. At 9:49 a.m., licensed assisted living director (LALD)-A confirmed the 911 emergency number and the required MAARC information was not posted in common areas and near telephones. LALD-A stated she was "not aware" of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 650	Continued From page 13	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an annual performance review was completed for one of one unlicensed personnel (ULP-C) with record	0 650		

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0 650	Continued From page 14	0 650		

reviewed.

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

The findings include:

ULP-C had a hire date of July 13, 2019, and provided services under the comprehensive home care license, and on August 1, 2021, began providing assisted living services.

On July 11, 2022, at 2:17 p.m., ULP-C was observed to administer medications to R1.

ULP-C's record included a Evaluation Form dated October 22, 2020.

ULP-C's record lacked evidence of an annual performance review being completed after October 22, 2020.

On July 13, 2022, at 8:56 a.m., licensed assisted living director (LALD)-A stated ULP-C "had a performance review completed. I can't find it."

The license's Employee Evaluation policy dated August 1, 2021, indicated all staff of the licensee would be given an employee evaluation at least annually. The evaluation form is to be signed by the supervisor and the employee. The original signed form is placed in the employee's personnel file and a copy of the completed and

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0 650	Continued From page 15 signed form will be given to the employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines and the Minnesota Department of Health (MDH). This had the potential to affect all residents, staff and visitors.	0 660		

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0 660	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB facility risk assessment dated July 28, 2021, indicated the licensee was a low risk. Unlicensed personnel (ULP)-C had a hire date of July 13, 2019, and provided direct care and services to the licensee's residents. On July 11, 2022, at 2:17 p.m., ULP-C was observed to administer medications to R1. ULP-C's record included a Serial TB Screening Tool for Health Care Workers (HCWs) completed on July 22, 2019, and a first step Tuberculin Skin Testing (TST) was administered on July 22, 2019, with read results of negative and "0" millimeters (mm) on July 24, 2019. The document had handwritten for second step TST "deferred 2nd step due to tuberculin shortage". ULP-C's record lacked a second step TST as required. On July 12, 2022, at 12:20 p.m., licensed assisted living director (LALD)-A confirmed ULP-C lacked a second step TST. LALD-A stated it was her "understanding the shortage pre pandemic [ULP-C] wouldn't need second step	0 660		

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0 660	Continued From page 17 testing." The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would 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 (MMWR). Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: - New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs - New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated Baseline TB screening is required for all HCWs (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single Interferon Gamma Release Assay (IGRA).	0 660		

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0 660	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure emergency	0 680		

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0 680	Continued From page 19 exit diagrams were posted, failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all three (3) residents in the facility, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EMERGENCY EXIT DIAGRAM The licensee lacked posted emergency exit diagrams in the facility and had not provided emergency exit diagrams to the residents. On July 12, 2022, at 9:42 a.m., no posted emergency exit diagrams were observed in any area of the facility. EMERGENCY PREPAREDNESS PLAN The licensee lacked a posted emergency disaster plan prominently and the licensee's Emergency Preparedness Plan dated August 1, 2021, lacked required information according to Emergency Preparedness: Appendix Z. On July 12, 2022, at 9:44 a.m., during observation of the facility, no posted emergency disaster plan was observed in any area of the facility. On July 13, 2022, at 11:36 a.m., licensed assisted	0 680		

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0 680	Continued From page 20 living director (LALD)-A was interviewed regarding the licensee's Emergency Preparedness Plan. LALD-A confirmed the licensee's Emergency Preparedness Plan lacked the following: - addressing how the licensee would coordinate with other health care facilities. as well as community on a whole during emergency or disaster; -arrangements/contracts to re-establish utility services; -develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans) - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care; identify which staff would assume specific roles in another's absence through succession planning and delegation of authority and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure addressing whether evacuated or shelter in place for staff/residents to maintain food, water medical supplies, pharmaceutical supplies; alternate sources of energy to maintain: 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 from the facility, including	0 680		

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0 680	Continued From page 21 consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - policy and procedure addressing shelter in place for residents, staff, and volunteers who remain in the 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 procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan which includes contact information for the following: Federal and MN Office of Ombudsman for LTC; -communication plan which includes primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & 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);	0 680		

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0 680	Continued From page 22 - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives -develop and maintain EP training and testing program, including reviewed/updated annually; -training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role, provide EP training at least annually, maintain documentation of all EP training and demonstrate staff knowledge of EP; -conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP, including the following: participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; analyze the facility ' s response to and maintain documentation of all drills, tabletop exercises and emergency events and revise plan as needed. On July 13, 2022, at 1:40 p.m., LALD-A confirmed there were no posted emergency exit diagrams posted on the upper or lower levels of the facility. At that time, LALD-A stated, "I have not provided	0 680		

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0 680	Continued From page 23 it to them", regarding providing emergency exit diagrams to the residents. LALD-A confirmed there was no posted emergency disaster plan in any area of the facility. The licensee's policy, Emergency Preparedness Plan Appendix Z Compliance dated August 1, 2021, indicated "It is the intent that Marcella Manor LLC has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance" and the licensee's "emergency preparedness plan will include all required elements of appendix Z." The licensee's policy, Disaster Planning and Emergency Preparedness dated August 1, 2021, indicated the licensee "will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. 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 emergency. All of these elements are incorporated into the Appendix Z requirements. Marcella Manor LLC will provide a building emergency exit diagram to all residents. Marcella Manor LLC will post emergency exit diagrams on each floor of the facility. Marcella Manor LLC will provide emergency and disaster training to all staff during initial staff orientation. Staff who have not received emergency and disaster training may only work when trained staff are working on site. Marcella Manor LLC will provide annual	0 680		

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0 680	Continued From page 24 emergency and disaster training to all staff. On an annual basis, Marcella Manor LLC will make available training regarding emergency and disaster response to all residents of the facility." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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	34666	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARCELLA MANOR LLC	228 19TH STREET SW ROCHESTER, MN 55902

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0 730	Continued From page 25 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documented information for	0 730		

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0 730	Continued From page 26 medical service providers. R1's Resident Information sheet dated July 11, 2022, listed the name and phone number for "pharmacy", but lacked the address of the pharmacy and listed "hospital preference" name, but lacked the address and phone number of the hospital. On July 13, 2022, at 10:45 a.m., registered nurse (RN)-B stated, "No, no not on there", regarding the above information being in R1's record. The licensee's Resident Record Information and Content policy dated August 1, 2021, indicated the resident record would include names, addresses, and telephone numbers of the resident's health and medical service providers, if known. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 790		

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0 790	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to document maintenance of fire extinguisher(s). 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, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On July 11, 2022, between 11:00 a.m. to 12:00 p.m., survey staff observed that the facility had no documentation associated to the annual inspection of fire extinguisher(s). Licensed assisted living director (LALD)-A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 28 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain their fire safety and evacuation plan, provide the required fire safety training and evacuation plans for residents and staff, and conduct and document drills. This has the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 29 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 the potential to affect a large portion or all residents). Findings include: On July 11, 2022, between 11:00 a.m. to 12:00 p.m., survey review of documentation showed the following: 1. No documentation was provided to confirm plans shows procedures for resident movement, evacuation map(s), or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation 2. No documentation was provided to confirm that the staff of the facility had received initial fire safety and evacuation training at the time of hire, as well as ongoing required twice per year thereafter. 3. Fire safety and evacuation plans may not be readily available to staff at all times, as currently only located on one floor of facility 4. No documentation was provided to confirm that residents who are capable of assisting in their own evacuation were being trained on proper actions at least once a year 5. No documentation was provided to confirm that	0 810		

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0 810	Continued From page 30 evacuation drills are being conducted twice per year per shift with at least one drill every other month Licensed assisted living director (LALD)-A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for	0 940		

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0 940	Continued From page 31 assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Resident Agreement was dated August 1, 2021. R1's contract indicated on page twelve (12), "22. Statements Related To Public Assistance Programs a) the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; d) medical assistance waivers provide payment for services, but do not	0 940		

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0 940	Continued From page 32 cover the cost of rent; governing bodies determine cost of rent for waivered services f) rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; the rent will be the standard amount as determined by governing bodies". R1's contract lacked the following required content: - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated, "It is not addressed and we haven't required that." LALD-A verified the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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01290	Continued From page 33 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for staff assisting in cares for one of one employee (unlicensed personnel (ULP)-C) with record reviewed. This has the potential to affect all residents receiving cares from the provider, and resulted in an immediate correction order on July 12, 2022, at approximately 1:43 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on July 13, 2019, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. On July 11, 2022, at 2:05 p.m. ULP-C was observed to administer medications to R3 and R1.	01290		

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01290	Continued From page 34 ULP-C's record contained a background study dated July 24, 2019, from a previously held comprehensive home care license, which expired on July 31, 2021. ULP-C's employee record lacked evidence the licensee affiliated a background study for the current assisted living license, which was effective August 1, 2021. On July 12, 2022, at 1:23 p.m. licensed assisted living director (LALD)-A stated, "I can't access my old HFID [facility identification number from prior comprehensive license] anymore." LALD-A stated, "I was able to access a couple months ago." On July 12, 2022, at 1:29 p.m. LALD-A provided an "employee list" from NETstudy for the current HFID of the assisted living license. The list did not have ULP-C listed as affiliated with the facility's assisted living license. LALD-A stated regarding ULP-C "she's not on the list." LALD-A further stated "not all employees were on the list" employed by the licensee under the assisted living license. On July 12, 2022, at 3:17 p.m. registered nurse (RN)-B stated, "Yes" ULP-C was providing cares directly to the licensee residents without direct supervision at times. The licensee's Background Studies policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at the licensee and no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received.	01290		

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01290	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On July 12, 2022, at 3:43 p.m. immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had documented instructions for a delegated task in the resident's	01420		

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01420	Continued From page 36 record and failed to ensure utilization of a gait belt as delegated for safety for one of one resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's observation progress note dated May 24, 2022, indicated the resident has had several falls in which she gave up while ambulating and needs to be lowered to the floor or have a chair brought to her. The resident is able to ambulate and requires frequent cueing and physical guidance to complete task. Staff directed to stand with resident when ambulating. Resident provider aware of falls; encourage safe transfers, use of assistive devices, reorientation as appropriate, hourly safety checks and fall mat. Staff directed to provide hands on assistance with gait belt as appropriate for safety. R3's Comprehensive Home Care Resource Manual Service Plan dated July 28, 2021, indicated R3 received assistance for the services of medication administration, treatments, bathing, hygiene/grooming, dressing, personal laundry, housekeeping and linen change and food preparation. R3's Comprehensive Home Care Resource Manual Service Plan lacked revision to include the services of mobility and walking standby assistance and transferring standby	01420		

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01420	Continued From page 37 assistance, including the use of a gait belt. On July 11, 2022, at 2:17 p.m., ULP-C stated for fall prevention the staff "always use a gait belt and walk with her" and R3 used a "walker" and R3 had a "mat on floor in room in case falls in room". On July 12, 2022, at 9:48 a.m., ULP-C was observed to be assisting R3 to walk form the living room area to R3 room. R3 was using a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. At 11:17 a.m., ULP-C was observed to assist R3 to walk from room back to living room. R3 used a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. ULP-C had to remind R3 to stop walking and move herself closer to her walker when assisting R3 to walk. R3's Task Administration Record dated July 2022, identified staff were signing for providing the services of mobility and walking standby assistance - provide standby assistance for resident with walking needs. Assist in morning and night during wake up and bedtime. Encourage use of assistive devices (walker, cane); transferring standby assistance - provide standby assistance for safety and cues and encouragement when needed; fall prevention (weekly to daily) client frequently falls (approximately one time per week or more) and requires alternative safety precautions, i.e. cane, walker, wheelchair, adaptive equipment, frequent supervision/assistance and/or bed alarm or chair alarm. Client may be resistive to safety devices; Safety hourly checks monitor resident every hour and document location/needs me. Report any concerns to supervisor immediately. R3's Task Administration Record lacked documented	01420		

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01420	Continued From page 38 evidence for use of mat on floor in room and gait belt. R3's electronic record service plan dated July 13, 2022, (provided as care plan) lacked documented evidence for use of mat on floor in room and gait belt. ULP-C's record identified ULP-C had successfully completed training and competency for transfer and ambulation on June 9, 2021, including full assist with the transfer belt/gait belt at all times; partial assist: staff has hands in contact with transfer belt/gait belt; standby assist: transfer/gait belt used, but no physical contact from staff unless necessary. On July 13, 2022, at 9:06 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B stated, "Yes, staff help transfer and ambulate" R3. RN-B stated staff utilize the gait belt with R3 "when [R3 was] manic use it more often" and stated staff "should be using it". LALD-A stated staff were educated after falls for R3. LALD-A stated R3 utilized nonstick socks and slippers, but when R3 was manic she had texture aversion. LALD-A stated she did not have "texture aversion" documented in R3's care plan. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated a registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The facility will establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff	01420		

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01420	Continued From page 39 and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. The registered nurse or licensed health professional will document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620		

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facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in condition for one of one resident (R3) related to falls, with record reviewed.

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

The findings include:

R3's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to falls, including implementation of interventions from review of causative factors to minimize the risk for future falls and potential injury.

R3's diagnoses included lumbar radicular syndrome, Parkinson's disease, diabetes, sciatica and bipolar disorder.

R3's Uniform Assessment Tool (comprehensive) was last completed on May 2, 2022.

R3's Comprehensive Home Care Resource Manual Service Plan dated July 28, 2021,

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01620	Continued From page 41 indicated R3 received assistance for the services of medication administration, treatments, bathing, hygiene/grooming, dressing, personal laundry, housekeeping and linen change and food preparation. On July 11, 2022, at 2:05 p.m., unlicensed personnel (ULP)-C was observed to administer medications to R3. R3 was seated in a recliner in her room with legs up in a reclined position. ULP-C applied pain relieving cream to both of R3's knees. R3's was observed to have multiple blue bruises on both knees. On July 11, 2022, at 2:17 p.m., ULP-C stated the bruises on R3's knees were from "fell couple times manic". ULP-C stated when R3 walks she drags her right leg at times, shakes and at times have to hold down right arm. ULP-C stated for fall prevention the staff "always use a gait belt and walk with her". ULP-C stated R3 "pushes call button around neck, good about that." ULP-C stated R3 used a "walker" and had a "mat on floor in case falls in room". ULP-C stated R3 can "fall anytime". On July 12, 2022, at 9:48 a.m., ULP-C was observed to be assisting R3 to walk form the living room area to R3 room. R3 was using a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. At 11:17 a.m., ULP-C was observed to assist R3 to walk form room back to living room. R3 used a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. ULP-C had to remind R3 to stop walking and move herself closer to her walker when assisting R3 to walk. R3's Task Administration Record dated July 2022, identified staff were signing for providing the	01620		

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01620	Continued From page 42 services of mobility and walking standby assistance - provide standby assistance for resident with walking needs. Assist in morning and night during wake up and bed time. Encourage use of assistive devices (walker, cane); transferring standby assistance - provide standby assistance for safety and cues and encouragement when needed; fall prevention (weekly to daily) client frequently falls (approximately one time per week or more) and requires alternative safety precautions i.e. cane, walker, wheelchair, adaptive equipment, frequent supervision/assistance and/or bed alarm or chair alarm. Client may be resistive to safety devices; Safety hourly checks monitor resident every hour and document location/needs me. Report any concerns to supervisor immediately. Toileting standby assistance -provide standby assistance for resident's toileting needs. R3's Task Administration Record lacked documented evidence for use of mat on floor in room and gait belt. R3's electronic record service plan dated July 13, 2022, (provided as care plan) indicated the same for services and cares as R3's Task Administration Record and lacked documented evidence for use of mat on floor in room and gait belt. R3's physician Evaluation and Management dated May 16, 2022, indicated repeated falls. Multiple falls recently - patient putting herself on floor and pretends to sleep, will wake and start singing -likely behavioral as patient is currently manic. Unwilling to participate in cares, causing patient to be lowered to floor. Bilateral primary osteoarthritis of knee, chronic pain in knees, a number of falls recently, slides off bed, is not strong enough to stop herself or get herself off	01620		

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01620	Continued From page 43 the floor. Takes gabapentin three time a day, has acetaminophen and trolamine cream (all used to treat pain). Assessment and Plan: encourage ambulation, use of pain cream. Heat/cold as tolerated. Lift chair. R3's record included the following Incident Reports (IR), IR Resident Follow Up (RFU) and Observation notes (situation, background, assessment, recommendation/SBAR): -IR dated May 19, 2022, 8:40 a.m. witnessed fall, staff attempting to assist resident from seated to standing off the bed when she slid down to the floor. She denied pain and laughed at staff. No injury. -observation note dated May 19, 2022, 12:30 p.m. S:fall follow up B: resident's is on day seven of manic episode; she has been depending on staff to complete all tasks for her. The resident's has had several falls in which she slide form her bed or bends forward, refusing to walk and falls to the floor despite staff standby/hands on assist. When she is sitting on the floor she will start laughing and singing. The resident is able to ambulate and requires frequent cueing and physical guidance to complete the task. Resident provider aware of falls; encouraging safe transfers, use of assistive devices, reorientation as appropriate and a fall mat. A: denies new pain, noted to have several healing bruises to arms legs and torso. R: Staff directed to stand with resident when ambulating. Staff directed to provide hands on assistance as appropriate for safety. Staff directed to provide single cues to encourage resident to complete the task. Staff directed to allow resident's time to sleep as she is better able to ambulate when rested and helps with her manic cycle. Staff directed to document and report concerns to nursing. Although the note included assessment,	01620		

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01620	Continued From page 44 there was no documented evidence in R3's record of nursing assessment beyond the documented entry of A: denies new pain, noted to have several healing bruises to arms legs and torso, or documented intervention being implemented related to sliding to the floor. -IRRFU dated May 20, 2022, (for fall May 19) contributing factors were reviewed. Client Follow Up Prevention: client Re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Client Follow Up Intervention: Prevention Trip hazards removed, injury prevention mat, clutter removed, non-skid mats, staff education. There was no documented evidence of intervention being implemented related to sliding to the floor. -IR dated May 23, 2022, 8:11 a.m. fall witnessed, resident was sitting on bed, slid to floor. No injury. -IR May 23, 2022, at 1:04 p.m. fall witnessed. resident's called staff needing to use the toilet. Staff assisted with getting her up, sitting in bed when slid down to floor. Staff let resident sit for awhile until she was ready to assist with getting up from floor. No injuries. -observation note dated May 24, 2022, at 10:00 a.m. S: manic/fall follow up B: resident's is on day 11 of manic episode; the mania seems to be less severe at this time. The resident has had several falls in which she gave up while ambulating and needs to be lowered to the floor or have a chair brought to her. The resident is able to ambulate and requires frequent cueing and physical guidance to complete task. Nursing discussed situation with provider who feels the behavior is	01620		

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01620	Continued From page 45 due to manic episodes. Resident provider aware of falls; encourage safe transfers, use of assistive devices, reorientation as appropriate, hourly safety checks and fall mat. A: resident's denies new pain; noted to have several bruises to arms, legs, torso. R: Staff directed to stand with resident when ambulating. Staff directed to provide hands on assistance as appropriate for safety. Staff directed to provide hands on assistance with gait belt as appropriate for safety. Staff directed to provide single cues to encourage resident to complete the task. Staff directed to allow resident's time to sleep as she is better able to ambulate when rested and helps with her manic cycle. Staff directed to document and report concerns to nursing. Although the note included assessment, there was no documented evidence in R3's record of nursing assessment beyond the documented entry of A: denies new pain, noted to have several bruises to arms legs and torso, or documented intervention being implemented related to sliding off the bed. -IR dated May 24, 2022, at 11:37 a.m. fall witnessed. Resident was ambulating with staff hands on assist. She required frequent cueing to keep hands on the walker and not grab shelving or door handles. The resident grabbed the door handle and the door moved and resident fell backwards on to her butt; staff attempted to slow the fall but was unable. After the fall, resident sitting on the floor up against her bed, laughing and talking on the phone. Resident refusing assistance to stand. Staff continued to check on resident every 15 minutes. After approximately 45 minutes, staff assisted resident to standing and placed her in a wheelchair. No injuries. Resident has multiple bruises to arms, legs, torso from previous falls.	01620		

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01620	Continued From page 46 -IRRFU dated May 25, 2022, (for fall May 23) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Client Follow Up Intervention: Prevention Trip hazards removed, injury prevention mat, clutter removed, non-skid mats, articles of need within reach, call light within reach, staff education. R3's record lacked documented evidence of intervention being implemented related to sliding off the bed. -IRRFU dated May 25, 2022, (for second fall May 23) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Nursing Reassessment. Client Follow Up Intervention: Prevention Trip hazards removed, injury prevention mat, clutter removed, non-skid mats, articles of need within reach, call light within reach, staff education. R3's record lacked documented evidence of intervention being implemented related to sliding off the bed. -IRRFU dated May 25, 2022, (for fall on May 24) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Nursing Reassessment. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, staff education. Although the IRRFU indicated a nursing assessment was completed for client follow up	01620		

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01620	Continued From page 47 intervention, there was no documented evidence in R3's record of a physical nursing assessment being completed after the fall or documented evidence of intervention being implemented related to grabbing door handle. -IR dated June 5, 2022, at 6:32 p.m. fall unwitnessed. Resident was trying to sit down onto the toilet, missed the toilet seat and fell down to the ground. She said her right lower hip was where it was hurting. I am guessing her side took most of the weight and she could have possibly hit the lip on the shower. I came in and was able to get her up onto the toilet. Resident kept saying "I am okay" but there is pain on her right side. Injuries: yes, she hit her right side pretty hard, will most likely form into a good sized bruise. -IRRFU dated June 6, 2022, (for fall on June 5) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Nursing Reassessment. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, call light within reach, furniture height adjusted, staff education. -observation note dated June 6, 2022, at 5:45 a.m. S: bruising follow up B: resident's recently completed manic episode. The resident has had several falls during the manic episode resulting in significant bruising; she does not recall the falls or the manic episodes. A: resident has several bruises to arms, legs and torso; varying in healing stages and color. She denies new pain, only reporting chronic pain in bilateral knees. R: Staff directed to provide standby assistance with resident when ambulating. Staff directed to	01620		

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01620	Continued From page 48 observe resident and document/report comments to nursing. Although the note included assessment, there was no documented evidence in R3's record of nursing reassessment beyond the documented entry of A: resident has several bruises to arms, legs and torso; varying in healing stages and color. She denies new pain, only reporting chronic pain in bilateral knees or documented intervention being implemented related to missing the toilet seat. -IR dated June 7, 2022, at 3:58 p.m. fall unwitnessed. Resident got done going to the bathroom and she got up and went to get floss. She then tried walking backwards to the toilet and fell backwards into the shower. I heard the boom and ran into the room. It looked like the left side took most of the impact and the lip of the shower was lined up with the bottom of the butt. She said that there was little pain on her left side, and said that her head didn't hurt. She said she was getting floss and then trying to go sit back down on the toilet and fell backwards. Injuries: yes, left side, and left side of her butt. -IRRFU dated June 8, 2022, (for fall June 7) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Nursing Reassessment. Fall assessment update. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, call light within reach, furniture height adjusted, staff education. Although the IRRFU indicated a nursing assessment/fall assessment update was completed for client follow up intervention, there was no documented evidence in R3's record of a nursing assessment	01620		

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01620	Continued From page 49 being completed after the fall or intervention being implemented. -IR dated June 12, 2022, at 9:20 a.m. fall unwitnessed. Staff gave resident's medication and went back to working on learnings, client stated she wanted to lay back down so staff got her situated back on the center of the bed. Client pushed her button and staff found her on the ground sitting right by her bed. Client wanted to get up herself, but had to call the nurse on call to help get resident up. No injuries noted. -IRRFU dated June 13, 2022, (for fall June 12) contributing factors were reviewed. Client Follow Up Prevention: client Re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, non skid mats, call light within reach, staff education. There was no documented evidence in R3's record of a nursing assessment being completed after the fall or intervention being implemented. -IR dated June 19, 2022, at 9:54 a.m. fall unwitnessed. resident pushed call light. Staff found resident on floor by bathroom door, laying on stomach. Staff did head to toe check, no redness or bruises. Then staff called nurse to assist getting resident's up form floor. No injuries. -IRRFU dated June 20, 2022, (for fall June 19) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and	01620		

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01620	Continued From page 50 ambulate. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, non skid mats, call light within reach, staff education. There was no documented evidence in R3's record of a nursing assessment being completed after the fall or intervention being implemented. -IR dated June 25, 2022, at 7:45 a.m. fall witnessed. resident pushed call light for staff assistance with getting up from bed, stating her knees hurt. Staff assisting her to seated position on bed and she slid down side of bed. Staff able to slowly lower her to the floor. Resident able to assist staff to standing position and then seated in chair. Resident requesting to use sit to stand for mobility to dining room for breakfast. Resident stated my knees are hurting and I am unable to walk. I want to eat in my room. No injuries. -observation note dated June 25, 2022, at 2:00 p.m. S: right knee pain B: resident complaining of right knee pain today that is worse than her normal pain. Resident's requested staff assistance to lift leg out of bed; when staff assisted she called out in pain and was grimacing. Staff slowly lowered leg and assisted resident's to standing; she reports difficulty with weight bearing and ambulation. Resident was able to walk short distance with hands on assistance. Staff documentation shows resident stayed in bed much of the afternoon/evening yesterday. Nursing encouraged resident to ambulate as able with staff assistance and perform daily scheduled therapy exercises to maintain strength. Nursing advised resident that when she stays in bed all day, it may cause an increase in her pain and encouraged her to walk short distances and sit in a recliner for periods during the day. A: Resident's has right knee pain	01620		

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01620	Continued From page 51	01620		

that is more intense than her chronic knee pain. No redness, swelling or deformities noted. R: Staff directed to encourage resident to walk short distances. Staff directed to discourage resident's from lying in bed long periods of time. Staff directed to utilize the sit to stand for assistance with ambulation for long distances. Staff directed to offer PRN medication. Staff directed to observe and report other concerns to nursing. There was no documented evidence in R3's record of a nursing assessment being completed after the fall or intervention being implemented.

-IRRFU dated June 27, 2022, (for fall June 25) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Client Follow Up Intervention: Prevention Trip hazards removed, clutter removed, non skid mats, call light within reach, staff education. There was no documented evidence in R3's record of a comprehensive nursing assessment being completed after the fall or intervention being implemented.

-IR dated June 29, 2022, at 9:18 a.m. fall unwitnessed. Staff found resident on floor by bathroom door. Addendum June 30, 2022, by RN-B: new bruising noted to left upper arm and left knee.

-IRRFU dated June 30, 2022, (for fall June 29) contributing factors were reviewed. Client Follow Up Prevention: client re-education encouraged several short walks each day along with daily exercises to maintain strength. Reminded to use call light and wait for staff to help transfer and ambulate. Client Follow Up Intervention:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 52 Prevention Trip hazards removed, clutter removed, non skid mats, call light within reach, staff education. There was no documented evidence in R3's record of intervention being implemented. -observation note dated June 30, 2022, at 1:15 p.m. S: bruising B: resident had unwitnessed fall yesterday morning with no apparent injuries at the time. Upon today's assessment new bruising noted to left upper arm ad left knee. A: resident has new bruising to left upper arm and left knee, purple in color. She denies pain; only reporting chronic pain in bilateral knees. R: Staff directed to observe/document and report concerns to nursing. Staff to continue to reminding resident to use call light for ambulation, transfers and staff to provide standby assistance with all transfers and ambulation. There was no documented evidence in R3's record of a comprehensive nursing assessment being completed after the fall. Although IR, IRRFU were completed and SBAR (at times) were completed for the above falls, R3's record lacked evidence of a documented comprehensive assessment by the RN for a change in condition related to the falls above, lacked evidence of documented staff education provided (as indicated for client follow up intervention) and implementation of interventions from review of causative factors/client follow up intervention to minimize the risk for future falls and potential injury. On July 11, 2022, at 2:54 p.m., licensed assisted living director (LALD)-A stated when a fall occurs staff "call nurse, take vitals, staff take directive from nursing. Twenty-four hours later nurse does follow up. Incident reports staff fill out. Incident investigation twenty-four hours later nurse fills	01620		

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01620	Continued From page 53	01620		

out. Yes, look for causative factors for change or educate resident". LALD-A stated, "Only nurse assessment if seems to be change in condition or if injury document in progress note".

On July 13, 2022, at 9:06 a.m., LALD-A and RN-B stated, "We raised [R3's] bed, didn't work. Lowered it back down. We don't know when becomes manic and truthfully sometimes she decides she doesn't want to walk and goes down to knees". LALD-A and RN-B stated, "Yes, staff help transfer and ambulate" R3. RN-B stated staff utilize the gait belt with R3 "when [R3 was] manic use it more often" and stated "your not wrong about gait belt [staff] should be using it". LALD-A stated staff were educated after falls for R3. LALD-A stated R3 utilized non stick socks and slippers, but when R3 was manic she had texture aversion. LALD-A stated she did not have "texture aversion" documented in R3's care plan. RN-B stated, "Very repetitive what we do. We educate her and staff stay close. What can we do? Exhausting options. [some staff] consistent with her. Trouble with other staff being consistent". When asked regarding no documented vitals after falls, RN-B stated, "Maybe miss communication sliding to floor, maybe why vitals aren't included". RN-B stated R3 had "tennis shoes" and "slippers with grippers" for walking. RN-B and LALD-A stated R3 "sits long times on toilet and staff have to go help someone else. Sits one to two hours on toilet listening to music. It has been a discussion can we meet her needs." LALD-A and RN-B stated R3 "walks with phone and walker. We remind put in pocket and give phone after". RN-B stated, "they have to be consistent", referring to staff. RN-B confirmed the last documented comprehensive assessment completed for R3 was dated May 2, 2022. LALD-a and RN-B stated R3 "finished therapy a

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01620	Continued From page 54 month ago. Left exercises and therapy band to do with her". LALD-A stated R3 was "independent with decision" for need of toileting. LALD-A confirmed the and RN-B confirmed the client follow up prevention and client follow up interventions on the IRRFU reports were repeated. The licensee provided Orientation and Training, Fall Risk and Prevention dated July 1, 2021, used for training with objective: staff will understand the risks of falls among the elderly and be able to: Identify fall risks; Encourage resident awareness to manage risk of falls; Understand the risks of restraints. Often there is not one single causative factor for a fall, but multiple factors. It is important that after each fall, including near falls (e.g., resident is lowered to the floor by staff), an incident report is completed and forwarded to the RN. The RN is responsible for following up on all falls, including completing a fall risk assessment, if necessary, and attempting to identify the causes of the fall and implement interventions to reduce the risk of future falls and injury (this is referred to as a root cause analysis or RCA). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 55 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan was revised, based on resident reassessment for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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:	01640		

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01640	Continued From page 56 R1 R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, indicated R1 received assistance for the services of medication administration, treatments, bathing, hygiene/grooming, dressing, continence, personal laundry, housekeeping and linen change and food preparation. On July 11, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Uniform Assessment dated May 31, 2022, indicated R1 needed assistance with activity participation monitoring, fall prevention, transfers and ambulation. R1's electronic record service plan dated July 11, 2022, (provided as care plan/lacked signatures) included services of mobility and walking standby assistance, transferring hands on assistance, shopping assistance, mobility stair chair hand on assist, safety checks every two hours while awake and hourly overnight, fall prevention, weekly vitals, COVID 19 vitals daily and activity participation monitoring. R1's Task Administration Record dated July 2022, identified staff were signing for providing the services of mobility and walking standby assistance, transferring hands on assistance, shopping assistance, mobility stair chair hand on assist, safety checks every two hours while awake and hourly overnight, fall prevention, weekly vitals, COVID 19 vitals daily and activity participation monitoring. R1's Comprehensive Home Care Resource Manual Service Plan lacked revision to include	01640		

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01640	Continued From page 57 the services of mobility and walking standby assistance, transferring hands on assistance, shopping assistance, mobility stair chair hand on assist, safety checks every two hours while awake and hourly overnight, fall prevention, weekly vitals, COVID 19 vitals daily and activity participation monitoring. R3 R3's Comprehensive Home Care Resource Manual Service Plan dated July 28, 2021, indicated R3 received assistance for the services of medication administration, treatments, bathing, hygiene/grooming, dressing, personal laundry, housekeeping and linen change and food preparation. On July 11, 2022, at 2:17 p.m., ULP-C stated for fall prevention the staff "always use a gait belt and walk with her" and R3 used a "walker". On July 12, 2022, at 9:48 a.m., ULP-C was observed to be assisting R3 to walk form the living room area to R3 room. R3 was using a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. At 11:17 a.m., ULP-C was observed to assist R3 to walk form room back to living room. R3 used a walker. No gait belt was observed to be utilized by ULP-C when assisting R3 to walk. ULP-C had to remind R3 to stop walking and move herself closer to her walker when assisting R3 to walk. R3's Task Administration Record dated July 2022, identified staff were signing for providing the services of mobility and walking standby assistance - provide standby assistance for resident with walking needs. Assist in morning and night during wake up and bed time. Encourage use of assistive devices (walker,	01640		

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cane) and transferring standby assistance - provide standby assistance for safety and cues and encouragement when needed.

R3's electronic record service plan dated July 13, 2022, (provided as care plan/lacked signatures) included services of mobility and walking standby assistance, toileting standby assist and transferring standby assistance.

R3's observation progress note dated May 24, 2022, indicated the resident has had several falls in which she give up while ambulating and needs to be lowered to the floor or have a chair brought to her. The resident is able to ambulate and requires frequent cueing and physical guidance to complete task. Staff directed to stand with resident when ambulating. Resident provider aware of falls; encourage safe transfers, use of assistive devices, reorientation as appropriate, hourly safety checks and fall mat. Staff directed to provide hands on assistance with gait belt as appropriate for safety.

R3's Comprehensive Home Care Resource Manual Service Plan lacked revision to include the services of mobility and walking standby assistance, toileting standby assist and transferring standby assistance, including the use of a gait belt.

On July 13, 2022, at 9:06 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B stated, "Yes, staff help transfer and ambulate" R3. RN-B stated staff "should be using it", referring to gait belt.

On July 13, 2022, at 10:45 a.m., LALD-A confirmed R1's Comprehensive Home Care Resource Manual Service Plan lacked revision to

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01640	Continued From page 59 include the above services. The licensee's Service Plan Modifications policy dated August 1, 2021, indicated when a resident received assisted living services and a change(s) to the service plan occurred, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 60 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included schizophrenia, weakness and unspecified abnormalities of gait and mobility. On July 11, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C was observed to administer medications to R1. On July 12, 2022, at 9:53 a.m., R1 was observed to have knee high compression socks on both lower extremities. R1 stated the staff "help put stockings on". R1's Comprehensive Home Care Resource	01650		

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01650	Continued From page 61 Manual Service Plan dated February 19, 2020, indicated for "description of services" R1 received assistance for the services of medication administration, treatments, bathing, hygiene/grooming, dressing, continence, personal laundry, housekeeping and linen change and food preparation; however, the service plan lacked specific description of what services were being provided for treatments, hygiene/grooming and the service plan did not reference a document for details of the services. R1's electronic record service plan dated July 11, 2022, (provided as care plan/lacked signatures) included the above services and oral care standby assistance (twice daily), shaving hands on assistance daily as needed and nail care hands on assist. In addition, the electronic record service plan identified the included services of mobility and walking standby assistance, transferring hands on assistance, shopping assistance, mobility stair chair hand on assist, safety checks every two hours while awake and hourly overnight, fall prevention, weekly vitals, COVID 19 vitals daily and activity participation monitoring, which were not included on R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020. R1's Task Administration Record dated July 2022, identified staff were signing for providing the above services according to R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, and electronic record service plan dated July 11, 2022. R1's Medication Administration Record dated July 2022, identified the staff were signing for the administration of knee high compression socks - apply in the morning and remove at night.	01650		

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01650	Continued From page 62 R1's Comprehensive Home Care Resource Manual Service Plan lacked the following: -description of services for treatments (compression socks) and for hygiene/grooming (oral care, shaving, nail care); -description of services, the fees for services, the frequency of each service and the identification of staff or categories of staff who would provide the services for: mobility and walking standby assistance, transferring hands on assistance, shopping assistance, mobility stair chair hand on assist, safety checks every two hours while awake and hourly overnight, fall prevention, weekly vitals, COVID 19 vitals daily and activity participation monitoring. In addition, R1's Comprehensive Home Care Resource Manual Service Plan indicated "contingency plan: if services cannot be provided the agency will proceed as follows: essential services arrangements will be made to ensure the client receives necessary services. (essential services are those services that cannot be postponed for the safety or medical wellness of the client. Services may include medications, oxygen, toileting, etc.) Describe service and action plan here:"; however, there was no documented evidence of the described service and action plan for essential services. R1's service plan lacked a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; and - identification of and information as to who has authority to sign for the resident in an emergency. On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A confirmed R1's	01650		

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01650	Continued From page 63 Comprehensive Home Care Resource Manual Service Plan lacked the above. LALD-A stated all residents would lack a contingency plan that included the action to be taken if the scheduled service cannot be provided and identification of and information as to who has authority to sign for the resident in an emergency. The licensee's Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services will have a service plan in place. The service plan would include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services g. A contingency plan that includes: i. Actions Marcella Manor LLC would take if scheduled services cannot be provided iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=D	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:	01750		

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01750	Continued From page 64 (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; (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 the registered nurse (RN) specified, in writing, specific instructions for administration of medications for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizophrenia. R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, included the services of medication administration. On July 11, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C was observed to administer	01750		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 65 medications to R1. R1's Medication Assessment and Medication plan was dated December 15, 2021. The plan indicated "Documentation: Any client specific requirements related to documentation of medication are located: on the electronic medication record (eMAR)". R1's Medication Administration Record (MAR) dated July 2022, included quetiapine (Seroquel) (antipsychotic, used for behaviors) 75 milligrams (mg) at bedtime and 12.5 mg in the morning, cough drops 5.8 mg take one tablet as needed for cough, Tussin DM liquid (cough syrup) take two teaspoons every four hours as needed for cough/congestion, mucus relief 400 mg take one tablet every four hours as needed for cough, bisacodyl enteric coated 5 mg take one tablet daily as needed for constipation, Miralax powder take 17 grams daily as needed for constipation, capsaicin 0.25% cream (muscle rub) apply to affected area up to three times daily as needed and muscle rub cream apply topically four times daily as needed. R1's electronic record service plan dated July 11, 2022, (provided as care plan/lacked signatures) identified "psychotropic medications using; using psychotropic medications related to specific behaviors: see MAR for medications. Appropriate use of medications will be maintained. No adverse affects related to psychotropic medication use. Behaviors to be controlled as allowed by progression of disease process." R1's observation progress notes dated June 10, 2022, indicated new order: resident has diagnosis of schizophrenia. Resident has been noted to be argumentative with staff when being redirected.	01750		

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	34666	A. BUILDING: _____ B. WING _____	07/14/2022

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01750	Continued From page 66 He also has been noted repeatedly ruminating about being schizophrenic, stating 'they ain't gonna get me thinking I'm paranoid schizophrenic. Nope, because I knows better". Provider was notified of the change in behavior and wrote the following order: quetiapine 12.5 mg by mouth in the morning and 75 mg by mouth at HS (bedtime). Resident has mild agitation, which is new for resident. Continued behaviors not new for resident include: circumstantial speech, grandiose delusions, compulsive behaviors, and impaired beliefs of reality. R1's MAR lacked specific instructions for parameters of which PRN medication to administer first for cough/constipation/muscle rub and lacked documented evidence of monitoring of behaviors for the administration of quetiapine used for schizophrenia. On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated staff do not have to call before giving am as needed medication. LALD-A confirmed R1's eMAR lacked specific instructions for parameters of which PRN medication to administer first for cough/constipation/muscle rub. LALD-A stated, "We don't have monitoring of behaviors" in place for R1 for the administration of quetiapine used for schizophrenia. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated when medication management is delegated to a ULP, the RN would specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided.	01750		

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01750	Continued From page 67 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01760		

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01760	Continued From page 68 The licensee lacked to administer medication at the time of noon per prescriber's orders. R3's record identified the following prescriber's orders: -dated August 22, 2021, atorvastatin 40 mg daily noon. -dated June 9, 2022, gabapentin 100 mg take two (2) capsule by mouth as directed. Take one (1) cap a.m. and two (2) caps noon times one week then one (1) cap a.m. and noon thereafter. On July 11, 2022, at 1:59 p.m., unlicensed personnel (ULP)-C was observed to administer atorvastatin 40 mg and gabapentin 100 mg to R3. R3's Medication Administration Record (MAR) dated July 2022, included atorvastatin 40 mg take one tablet by mouth at 2 p.m. and gabapentin 100 mg take one capsule by mouth in the morning and at 2 p.m. The MAR identified ULP-C signed for administration of the medications at 2:00 p.m. R3 was administered the atorvastatin and gabapentin at 2:00 p.m. instead of at noon as prescribed. On July 12, 2022, at 11:44 a.m., licensed assisted living director (LALD)-A stated, "I'll take the responsibility for that", referring to R3 being administered the medications above at 2:00 p.m. instead of at noon time as prescribed. LALD-A stated R3 "doesn't take a.m. pill until gets up. We try to get her up by 9:00 a.m. and the a.m. pill is scheduled at 8:00 a.m. to give" referring to gabapentin. LALD-A stated she had scheduled the dose at 2 p.m. instead of noon due to R3 taking the morning dose later to keep enough time between doses. LALD-A confirmed the	01760		

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01760	Continued From page 69 provider had not been contacted regarding the time change for the medications from noon as prescribed to 2:00 p.m. LALD-A stated, we "need to clarify times with doctor". The licensee's Medication and Treatment Orders Renewal policy dated August 1, 2021, indicated residents who receive medication management services by the licensee would have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident (R1) had signed prescriber's order for medication with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01820		

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01820	Continued From page 70 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked a prescriber's order for as needed (PRN) muscle rub cream (used for pain). On July 11, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Medication Administration Record (MAR) dated July 2022, included muscle rub cream apply topically to affected area(s) four times daily as needed. R1's record lacked documented evidence of a prescriber's order for the administration of the medication. On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated, "We just don't have copies from the pharmacy. The pharmacy would have to have current prescriptions to send the medications." LALD-A verified R1's record lacked documented evidence of a prescriber's order for the muscle rub. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the registered nurse (RN) was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided.	01820		

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01820	Continued From page 71 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, included the services of medication administration. On July 11, 2022, at 2:17 p.m., unlicensed personnel (ULP)-C was observed to administer medications to R1.	01830		

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01830	Continued From page 72 R1's Medication Administration Record (MAR) dated July 2022, indicated R1 received one medication for schizophrenia, one for hemorrhage, one for supplement, one for acid reflux, five for pain, three for cough, one for indigestion, one for sleep, one for fungal infection and two for constipation. R1's record included prescriber orders for the following: -June 9, 2022, quetiapine (used for schizophrenia) 12.5 milligrams (mg) in the morning and 75 mg at bedtime; and -August 18, 2021, acetaminophen (Tylenol) (used for pain) 1000 mg three times per day scheduled. R1's record included the following prescriber's orders, but lacked renewal at least every 12 months for the following: -dated July 2, 2021, gabapentin 300 mg at bedtime for pain; -dated April 26, 2021, for the following; bisacodyl 5 mg tablet daily for constipation capsaicin 0.025% cream (muscle rub) apply to affected area three times daily as needed for pain cough drops 5.8 mg one lozenge as needed for cough famotidine 20 mg daily for acid reflux melatonin 3 mg at bedtime as needed for sleep guaifenesin 400 mg tablet every four hours as needed for cough muscle rub ultra strength cream to affected areas four times daily as needed for pain Miralax 17 grams daily as needed for constipation stomach relief 262 mg chewable two tablets as needed every 30 to 60 minutes for indigestion terbinafine topical apply to affected areas two times daily as needed for fungal infection thera m tablet one tablet daily for hemorrhage	01830		

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01830	Continued From page 73 zinc sulfate 220 mg daily with breakfast for supplement tussin dm liquid two teaspoons as needed every four hours for cough On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated, "We just don't have copies from the pharmacy. The pharmacy would have to have current prescriptions to send the medications." LALD-A verified R1's record lacked documented evidence of renewal for the above prescriptions at least every 12 months. The licensee's Medication and Treatment Orders Renewal policy dated August 1, 2021, indicated residents who receive medication management services by the licensee would have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. Medication and treatment/therapy orders would be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940		

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01940	Continued From page 74 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individualized treatment or therapy management record to include all required content and was revised with changes for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01940		

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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's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, indicated for "description of services" R1 received assistance for the services of treatments; however, the service plan lacked specific description of what services were being provided for treatments and the service plan did not reference a document for details of treatment services.

On July 12, 2022, at 9:53 a.m., R1 was observed to have knee high compression socks on both lower extremities. R1 stated the staff "help put stockings on".

R1's record included a prescriber's order dated May 1, 2022, order two pair of compression stockings. Apply in the morning and remove in the evenings.

R1's Treatment/Therapy management Plan dated November 1, 2021, indicated "services being provided/delegated to unlicensed personnel (ULP) include: occupational therapy, physical therapy, range of motion (ROM), vital signs (provider ordered). Documentation of specific client instructions relating to the administration of treatments/therapy is located: in electronic health records (EHR)/service tasks. Staff will notify a licensed nurse or appropriate health professional when a problem arises with treatment/therapy

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management services, including refusals and potential treatment inaccuracies. Specific parameters regarding treatments are in EHR/service tasks. Monitoring of treatment or therapy to prevent possible complications or adverse reactions is located; on the client treatment administration record (TAR), in EHR/service tasks."

R1's Task Administration Record dated July 2022, identified staff were signing for providing the services of "weekly vitals take their vital weekly on Wednesday and as needed."

R1's Medication Administration Record dated July 2022, identified the staff were signing for the treatment administration of "KH [knee high] compression socks - apply in the morning and remove in the evening. Rinse with soap and water and hang to dry once removed."

R1's electronic record service plan dated July 11, 2022, (provided as care plan/lacked signatures) identified "weekly vitals" take their vitals weekly on Wednesday and as needed. Vitals: blood pressure, pulse, respirations, weight.

R1's Treatment/Therapy management Plan lacked the following:
-a statement of the type of services that would be provided (compression socks);
-documentation of specific resident instructions relating to the treatments or therapy administration (parameters related to vitals ordered by provider);
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel (compression stockings);
-procedures for notifying a registered nurse or appropriate licensed health professional when a

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01940	Continued From page 77 problem arises with treatments or therapy services (compression stockings/vitals ordered by provider); In addition, R1's treatment plan lacked to be updated with changes in treatment services (treatments on the plan not being managed by the licensee/occupational therapy, physical therapy, ROM). On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A confirmed R1's treatment plan lacked revision to include compression stockings and lacked to be updated regarding treatment services not being managed by the licensee. LALD-A stated R1 had physical/occupational therapy "in the past" and "does exercises [ROM] on his own". LALD-A stated vitals were "ordered by provider one times per week". LALD-A stated she "was not thinking of them as a treatment", referring to compression stockings. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the registered nurse (RN) or licensed health professional will document instructions for the delegated tasks in the resident's record. A RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. These services include, but are not limited to: Treatment and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01950		

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01950	Continued From page 79 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Comprehensive Home Care Resource Manual Service Plan dated February 19, 2020, indicated for "description of services" R1 received assistance for the services of treatments; however, the service plan lacked specific description of what services were being provided for treatments and the service plan did not reference a document for details of treatment services. On July 12, 2022, at 9:53 a.m., R1 was observed to have knee high compression socks on both lower extremities. R1 stated the staff "help put stockings on". R1's record included a prescriber's order dated May 1, 2022, order two pair of compression stockings. Apply in the morning and remove in the evenings. R1's Treatment/Therapy management Plan dated November 1, 2021, indicated "services being provided/delegated to unlicensed personnel (ULP) include: occupational therapy, physical therapy, range of motion (ROM), vital signs (provider ordered). Documentation of specific client instructions relating to the administration of treatments/therapy is located: in electronic health records (EHR)/service tasks. staff will notify a licensed nurse or appropriate health professional when a problem arises with treatment/therapy management services, including refusals and potential treatment inaccuracies. Specific	01950		

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	34666	A. BUILDING: _____ B. WING _____	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 80	01950		

parameters regarding treatments are in EHR/service tasks. Monitoring of treatment or therapy to prevent possible complications or adverse reactions is located; on the client treatment administration record (TAR), in EHR/service tasks."

R1's Task Administration Record dated July 2022, identified staff were signing for providing the services of "weekly vitals take their vital weekly on Wednesday and as needed."

R1's Medication Administration Record dated July 2022, identified the staff were signing for the treatment administration of "KH [knee high] compression socks - apply in the morning and remove in the evening. Rinse with soap and water and hang to dry once removed."

R1's electronic record service plan dated July 11, 2022, (provided as care plan/lacked signatures) identified "weekly vitals" take their vitals weekly on Wednesday and as needed. Vitals: blood pressure, pulse, respirations, weight.

R1's record lacked documentation of specific resident instructions relating to the treatments or therapy administration for parameters related to vitals ordered by provider and compression stockings.

On July 13, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A confirmed R1's treatment plan lacked revision to include compression stockings. LALD-A stated she "was not thinking of them as a treatment", referring to compression stockings. LALD-A confirmed R1's record lacked documented specific resident instructions relating to the treatments or therapy administration for vitals ordered by provider and

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01950	Continued From page 81 compression stockings. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the registered nurse (RN) or licensed health professional will document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	02260		

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02260	Continued From page 82 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: The licensee lacked written or electronic form notice of dementia training. On July 12, 2022, at 3:48 p.m., licensed assisted living director (LALD)-A stated, "Yes, absolutely" the licensee would provide care to persons with dementia. On July 13, 2022, at 9:01 a.m., LALD-A stated, "I looked, didn't find it, but I go over verbally for people who ask", regarding the licensee having a written or electronic form notice of dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and	02310		

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02310	Continued From page 83	02310		

services were provided according to acceptable health care and medical, or nursing standards with bedrails/side rails, for one of one resident (R1) with record reviewed. This resulted in an immediate correction order on July 11, 2022, at approximately 2:30 p.m.

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

The findings include:

R1's Service Plan dated September 10, 2020, noted services included medication administration, treatment administration, bathing/grooming/hygiene/dressing/continence assistance, personal laundry, housekeeping/linen changes and food preparation.

On July 11, 2022, at 10:43 a.m. R1's bed was observed with licensed assisted living director (LALD)-A to have one half side rail in the upright position on the left and right upper halves of the bed. The bedrail measurements for zone 1 were found to be within the highest length of 4.0 inches by the highest width of 8.50 inches, zone 2, 3 and 4 no spaces, zone 5 not applicable, zone 6 - 8.25 inches and zone 7 - 3.5 inches. The bedrails were securely attached to the bed.

On July 11, at 11:41 a.m. R1 stated he used the side rails so when he "turns over he won't hit the floor" and he "holds it to stand up." R1 stated, "Oh

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02310	Continued From page 84 yeah, the boss lady excellent, very cautious, explained the dangers and all." R1's record identified the following: -prescriber order dated July 14, 2021, semi-electric hospital bed with mattress and side rails -90 day assessment dated May 31, 2022, which indicated R1 was alert and independent with decision making -Physical Device Assessment dated November 1, 2021, identified using hospital bed to optimize independence and enhancement and maximization to participate in cares. The "device needed" section of the assessment did not identify use of side rails. In addition, there was a check mark indicating "risk/benefits of each device had been reviewed with the client/family"; however, lacked documented specifics of risk and benefits explained and an assessment of the resident's ability to utilize the side rails safely. -Individual Abuse Prevention Plan (IAPP) 90 day assessment dated May 31, 2022, indicated vulnerability of side rail/bed positioning device assessment in place, side rail/bed positioning device agreement in place (risk and benefit), safety checks of side rail/bed positioning device every shift when in use, staff to report any concerns with side rails/bed positioning device to nurse promptly and listed goal/outcome/plan. R1's record lacked documented evidence of bedrail measurements for zones one through seven according to Food and Drug Administration (FDA) guidelines, documented specifics of risk and benefits explained, an assessment of the resident's ability to utilize the side rails safely and lacked documented evidence of safety checks of the siderails being completed every shift as indicated on the IAPP.	02310		

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02310	Continued From page 85 On July 11, 2022, at 9:30 a.m. LALD-A stated R1's "provider [doctor] ordered the bed with the side rails. I contacted a medical supply [company] and that's what they delivered. I haven't done measurements". LALD-A stated she was aware of the FDA guidelines. LALD-A stated she had "talked to [R1], he could get tangled, cause fall or worse", regarding the risks of using the side rails. LALD-A stated, "Nothing documented" specific about the risk and benefits. LALD-A stated there was "no documentation" of staff checking the side rails for safety as mentioned in R1's IAPP. At 1:41 p.m. LALD-A confirmed R1's record lacked an assessment of the resident's ability to utilize the side rails safely. LALD-A stated, "I will add it to the physical device assessment", regarding an assessment of the resident's ability to utilize the side rails safely. The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any	02310		

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02310	Continued From page 86	02310		

kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.

The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4. Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth. Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches. Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space

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02310	Continued From page 87 should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches. Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle. Zone 5, 6, and 7 are identified as potential for entrapment with the least reporting. Zone 5 is the area between the split of bedrails, zone 6 is the between the end of rail and the side edge of the head or footboard, and zone 7 is between the head of footboard at the end of the mattress. The licensee's Side Rails policy dated August 1, 2021, indicated when the licensee was aware a resident was utilizing siderails (a medical device) on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use was of a safe design and utilized consistent with the manufacturer's directions. When side rails are in use an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. Education provided would be documented in the resident record. The policy further indicated staff would determine if the side rail was considered safe and referenced the FDA's 2006 recommended dimensional measurements zones 1, 2 and 3 "must not exceed 4.75". The policy did not address FDA guidelines for zones 4 through 7.	02310		

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02310	Continued From page 88 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On July 11, 2022, at 3:07 p.m. immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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 the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	03090		

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03090	Continued From page 89 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: On July 11, 2022, at approximately 9:30 a.m., upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On July 11, 2022, at 2:54 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated, "I don't", regarding the licensee having the required statutory language to disclose electronic monitoring posted. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated signs were installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/12/22*
Time: 10:13:14
Report: 7920221117

Food and Beverage Establishment Inspection Report

Location:
Marcella Manor Llc
228 19th Street Sw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0037605
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072725148
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.

Food and Equipment Temperatures

Process/Item: Refrigerator
Temperature: 35 Degrees Fahrenheit - Location: Fruit, vegetables, dairy
Violation Issued: No

Process/Item: Freezer
Temperature: 5 Degrees Fahrenheit - Location: Buns, bread, vegetables
Violation Issued: No

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

I acknowledge receipt of the inspection report number 7920221117 of 07/12/22.

Certified Food Protection Manager: Heather Post

Certification Number: SS Expires: / /

Signed: _____
Establishment Representative

Signed: 
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us